Eastgate Dental Practice Limited

Eastgate Dental Practice

Inspection Report

1- 4 Eastgate Court
High Street
Rochester
Kent
ME1 1EU
Tel:01634 841337
Website:

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Overall summary

We carried out an announced comprehensive inspection on 10 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Back Ground

Eastgate Dental Practice is a mixed dental practice providing both NHS and private treatment. The practice caters for children and adults and is situated in Rochester, Kent. The practice provides services on three split levels and has three treatment rooms, an OPG (Orthopantomograph – an oral x-ray machine), reception and two waiting areas.

The practice has five dentists (the principal dentist, three associates and a salaried dentist). The dentists are supported by seven dental nurses who have dual roles and act as receptionists, one of whom is the practice manager. Dental services are provided from Monday to Friday 9am to 5.30pm and on Saturdays from 9am to 1pm.

Before our inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of using the practice. We collected nine completed cards. All provided a positive view of the service the practice provides. We spoke with five patients who commented that the team were kind, caring, efficient and that they had received very good care. They all commented that the practice was very clean and that staff treated patients with dignity and respect. Patients told us they had sufficient time during consultations with staff and felt listened to as well as safe.

Our key findings were:

Summary of findings

- Staff reported incidents and kept records of these which were used for shared learning and improvement.
- The practice was visibly clean and well maintained.
- Patients' needs were assessed and care and treatment was planned and delivered in line with current guidance.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding vulnerable adults and children.
- The practice placed an emphasis on the promotion of good oral health and provided regular oral health advice to patients.
- Staff had received training appropriate to their role and were supported in their continued professional development.
- Information from nine completed comment cards gave us a positive picture of a friendly, caring, professional service.
- The practice took into account comments, suggestions or complaints and used these to make improvements to the service.
- Staff were well supported and were committed to providing a quality service to their patients.

There were areas where the provider could make improvements and should:

- Review the practice's infection control procedures and protocols to ensure they are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Review the way in which clinical waste is disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Revise the practices processes to ensure there is an effective system to assess, monitor and mitigate the risks arising from fire safety requirements.
- Review the practice's arrangements for informing staff of patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the current legionella risk assessment, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the practice's recruitment policy and procedures to ensure that proof of identification are requested and recorded suitably, for all staff. As well as obtaining and recording a full employment history for existing employees.
- Review its complaint handling procedures and establish an accessible system for recording, handling and responding to verbal complaints by patients.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had effective and efficient processes for the management of medical emergencies and dental radiography (X-rays). The equipment in the practice was well maintained in line with the manufactures instructions. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from incidents and accidents.

However, there were issues identified with;

- How national patient safety and medicine alerts that effected the dental profession, recorded and cascaded to the staff team.
- The spread of infection had not always been minimised, in that records viewed showed that a legionella test had been carried out in 2012 but no further testing had been conducted, despite the policy stating it should be conducted every two years, there were toilet brushes in the public toilets, that fabric chairs in the waiting room were not being steam cleaned as part of the cleaning schedule, foot covers on the consultation chairs in two rooms were cracked and in one consultation room the shoulder rest had a split in the fabric. Additionally, bags of clinical waste were being taken through the staff room and stored in a contained doorway.
- The practices fire risk assessment which did not include details of how and when fire drills would be carried out. Additionally, there were limited records of fire drills having been recorded.
- Records showed that not all of the relevant checks had been carried out before new staff were employed. For example, proof of identity. Additionally, in existing staff files we saw that they did not have copies of a CV or a record of their work history.

We raised these issues with the principal dentist, who subsequently sent us documentary evidence to show that these areas of high risk had been addressed within the required timescale following our visit.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. Staff had received training in safeguarding and were aware of their responsibilities to protect vulnerable adults and children.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

The care and treatment provided by the practice was evidence based and focused on the individual needs of the patients. The practice used national guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive team work and evidence of good communication with dental professionals. Staff received training and development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC), completed frequent continuing professional development which was meeting the requirements of their professional registration.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

We collected nine completed comment cards which were all positive. We spoke with five patients and discussed their experiences. All of the information we received from patients provided a positive view of the service the practice provided. Patients told us that the care and treatment they received was caring, patient and thorough. They praised the skills of the clinical staff and the professionalism of the whole practice team.

Summary of findings

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice provided clear information to patients about the costs of their treatment. Patients could access treatment and urgent care when required. The practice was all on two split levels with access into the building by a ramp for patients with mobility difficulties and families with prams and pushchairs. The team had access to translation services if they needed.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

The principal dentist and associates worked closely together to co-ordinate the day to day running of the practice. Staff were aware of the way forward and vision for the practice. The practice used quality assurance processes to assist them to maintain the quality of the service. However, the systems and process had failed to identify the issues with the control and prevention of infection and the fire risk assessment had failed to identify risks associated with not recording fire drills and evacuations. As well as, appropriate recruitment checks for all staff.

Eastgate Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This was an announced inspection and was carried out on 10 March 2016 by two CQC inspectors.

We informed NHS England area team and local Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection we spoke with the principal dentist, two dental nurses/receptionists and the trainee dentist. We looked around the premises, reviewed operational polices, dental care records staff files and observed decontamination processes.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Learning and improvement from incidents

The practice had an adverse incidents reporting policy and reporting forms for staff to complete when something went wrong. All staff we spoke with were aware of the systems to follow which included recording, investigation, analysis and reduction of risk. One incident had occurred within the last 12 months. Records confirmed that the incident had been investigated, risks reduced and shared with staff.

The practice had a system to manage national patient safety and medicine alerts that effected the dental profession. The practice received these by email. We were told by the principal dentist that these were then cascaded to the staff team and discussed at practice meetings. However, records of meetings did not contain evidence of such discussions having taken place. We raised this issue with the principal dentist, who subsequently sent us documentary evidence to show that this area of risk had been addressed within the required timescale following our visit.

Records we viewed reflected that the practice was following national guidance in relation to the control of substances hazardous to health (COSHH). All substances in use at the practice had been risk assessed and measures implemented to keep staff and patients safe.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the safeguarding lead and had completed the appropriate level of training to hold this role. All staff had received safeguarding training for children and vulnerable adults. All staff we spoke with were aware of the procedure they would have to follow if abuse or neglect was suspected. They were clear on who to contact at the practice or externally if the need arose. Safeguarding guidance was available to staff and contained details of external organisations that could offer support. This included contact details of the local authority safeguarding teams.

The dentists we spoke with on the day of our inspection told us that they did use a rubber dam for root canal treatments (endodontics). A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal and to control moisture.

Patients attending the practice had their medical history reviewed on each occasion. This ensured that any health conditions or medicines could be considered before prescribing or deciding on certain treatments. New patients were required to complete a comprehensive medical and lifestyle form which was reviewed at each visit. The details of patient's medical conditions, medicines, lifestyle choices (such as smoking) were recorded on the electronic dental care records as well as a hard copy.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures.

This assured us that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. The principal dentist was the lead with responsibility for infection prevention and control (IPC). We saw that dental treatment rooms and the general environment were clean, tidy and clutter free.

Feedback confirmed that the practice maintained high standards regarding this at all times. The practice employed a cleaner for general cleaning at the practice and we saw that cleaning equipment was safely stored in line with guidance about colour coding equipment for use in different areas of the building.

During the inspection we observed that the dental nurses cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the practice had a supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel

available. All treatment rooms had designated hand wash basins separate from those used for cleaning instruments.

Are services safe?

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. The practice had a well-defined system which separated dirty

instruments from clean ones in the treatment rooms using the temporal separation method. The dental nurses cleaned, checked and sterilised instruments in each surgery. All of the nurses at the practice had been trained so that they understood this process and their role in making sure it was correctly implemented.

The dental nurse showed us the full process of decontamination including how staff rinsed the

instruments, checked them for debris and used the autoclaves (equipment used to sterilise dental

instruments) to clean and then sterilise them. Clean instruments were packaged and date stamped according to current HTM01-05 guidelines. They confirmed that the nurses in each treatment room checked to make sure that they did not use packs which had gone past the date stamped on them. Any packs not used by the date shown were processed through the decontamination cycle again.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. They showed us the paperwork they used to record and monitor these checks. These were fully completed and up to date. However, the decontamination system was not operational on the day of our inspection and hadn't been for some time. We observed staff hand cleaning and decontaminating equipment and this was completed effectively and in line with good practice. We raised these issues with the principal dentist, who subsequently sent us documentary evidence to show that this area of risk had been addressed within the required timescale following our visit.

The practice used single use dental instruments whenever possible which were never re-used and the special files used for root canal treatments were used for one treatment.

There was an infection control protocol and staff had received up to date training. Records viewed confirmed this.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. The practice had a comprehensive Legionella policy. Records viewed showed that a legionella test had been carried out in 2012. However, no further testing had been conducted, despite the policy stating it should be conducted every two years. Legionella is a bacterium which can contaminate water systems. We raised these issues with the principal dentist, who subsequently sent us documentary evidence to show that this area of risk had been addressed within the required timescale following our visit. We saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of Legionella. The practice used a recognised flushing method to prevent a build-up of legionella biofilm in the dental waterlines. Regular flushing of the water lines was carried out in accordance with the manufacturer's instructions and current guidelines.

The practice also completed an annual IPC report in line with guidance from the Department of Health code of practice for infection prevention and control. Records confirmed that annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. However, we observed that there were toilet brushes in the public toilets, fabric chairs in the waiting room were not being steam cleaned as part of the cleaning schedule, foot covers on the consultation chairs in two rooms were cracked and in one consultation room the shoulder rest had a split in the fabric. This meant that the risk of the spread of infection had not always been minimised. We raised these issues with the principal dentist, who subsequently sent us documentary evidence to show that these areas of risk had been addressed within the required timescale following our visit.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. There were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument including the contact details for the local occupational health department.

The practice did not always store their clinical and dental waste in line with current guidelines from the Department of Health. We found that bags of clinical waste were being taken through the staff room and stored in a contained doorway. This meant that clinical waste for disposal was not being managed in line with guidance. We raised these issues with the principal dentist, who subsequently sent us

documentary evidence to show that this area of risk had been addressed within the required timescale following our visit. The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices.

Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. The practice had an appropriate policy and used a safe system for handling syringes and needles to reduce the risk of sharps injuries.

Equipment and medicines

We looked at the maintenance schedules and routine, daily and weekly testing regimes for the equipment used at the practice. All records demonstrated that equipment was maintained in accordance with the manufacturer's instructions. This included equipment's used in the decontamination and sterilisation of dental instruments, X-ray equipment and the medical emergency equipment.

All electrical equipment had been portable appliance (PAT) tested using an appropriate qualified person.

The practice recorded medicines prescribed and administered such as local anaesthetic. We saw from a sample of dental care records that dentists had recorded the type of local anaesthetic used, the dose, area of administration and the batch number and expiry dates.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and had carried out a number of risk assessments to ensure the safety of patients and others who attended the premises. There was a record of identified risks and action plans to manage or reduce risk dated within the last 12 months. For example, the risk of scalds and burns when staff used the autoclave (a piece of equipment used to steam sterilise surgical instruments under pressure).

The practice had an up to date fire risk assessment. However, this did not include details of how and when fire drills would be carried out. We were told by staff that fire drills were conducted during staff meetings and recorded in the meeting minutes. However, over a period of 14 months only one drill had been recorded and there was no record of an evacuation being carried out. We raised these issues with the principal dentist, who subsequently sent us documentary evidence to show that these areas of risk had been addressed within the required timescale following our visit.

The practice had a business continuity plan that outlined the procedures to follow and people to contact in the event that services were disrupted. This included a reciprocal arrangement with another practice in the area. The plan included extreme situations such as loss of the premises due to fire or flooding, loss of utilities and staff shortages due to pandemic illness. Staff told us that copies of the plan were held off site so the information was always accessible.

Medical emergencies

All staff had received training to equip them to manage a medical emergency and this was repeated at appropriate intervals. Emergency medicines and equipment, including an automated external defibrillator (AED, a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal

heart rhythm) and oxygen were readily available. All staff knew the location of the emergency medicines and equipment and could retrieve it quickly if required.

The emergency medicines and equipment held by the practice reflected the Resuscitation Council UK and the British National Formulary (BNF) recommendations. The arrangements for managing medicines for use in an emergency in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Records showed that they were routinely checked to ensure they were within their expiry date. However, not all of the emergency equipment could be verified as in date, as oxygen masks had not been stored in their original packaging. We raised this with the principal dentist, who subsequently sent us documentary evidence to show that these areas of high risk had been addressed within the required 48hrs following our visit. We looked at records showing that emergency equipment was checked, monitored and replaced regularly.

Staff recruitment

The practice had an effective recruitment and selection policy that ensured patients were cared for and supported by suitably qualified, skilled and experienced staff.

Are services safe?

We looked at records of staff employed at the practice. Records showed that not all of the relevant checks had been carried out before new staff were employed. For example, proof of identity. Additionally, in existing staff files we saw that they did not have copies of a CV or a record of their work history. The staff files did however, contain an application form, attendance at an interview, satisfactory references, confirmation of current General Dental Council (GDC) registration, current professional indemnity cover, immunisation status and a police records check from the Disclosure and Barring Service (DBS). All these checks helped to make sure that only people who were deemed suitable were employed. Staff that we spoke with indicated that they had received a comprehensive job description and were clear about the roles and responsibilities expected of them. We saw copies of job descriptions on the staff files viewed.

Radiography (X-rays)

The practice was working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).

They had a named Radiation Protection Adviser and Supervisor and a well maintained radiation protection file. This contained the required information including the local rules and inventory of equipment, critical examination packs for each X-ray machine and the expected three yearly maintenance logs.

We saw evidence that the dentists recorded the reasons why they had taken X-rays and that X-rays were always checked to ensure the quality and accuracy of the images. We saw clinical audit records for the quality of the X-rays they took; this showed they were monitoring their performance in this aspect of dentistry.

The dentists and dental nurses involved in taking X-rays had completed the required training. Radiography standards at the practice were extremely high.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment and detailed how that consent should be recorded.

Staff told us that they obtained either verbal or written consent from patients before carrying out examinations, tests, treatments, arranging investigations or referrals and delivering care. They said that parental consent given on behalf of children was documented in the child's dental records. Patient records that we sampled showed that consent forms were completed appropriately and kept on the patients file, both in hard copy and electronically. Staff also told us that patients could withdraw their consent at any time and that their decisions were respected by the practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff were aware of the MCA and could demonstrate how it would apply to their work.

Monitoring and improving outcomes for people using best practice

The principal dentist and dental nurses confirmed the length and frequency of patients appointments were based on their assessed treatment needs so that each patient was given time without rushing. Comments received from patients reflected this. In particular when booking appointments so that families could attend at the same time.

During our visit we found that care and treatment was planned and delivered in a way that ensured patients safety and welfare. We saw that a full medical history and list of medicines had been recorded in the patient record and had been reviewed regularly.

We looked at a range of clinical and practice wide audits that had been carried out to help staff monitor the effectiveness of the service they provide. This included the recall of patients in line with their needs assessments, antibiotic prescribing and referrals to other services.

Working with other services

The practice had a structured system with regard to working with and making referrals to other services such as NHS community dental services and practices specialising in specific aspects of dentistry. We saw evidence that the practice liaised with other dental professionals and made

appropriate referrals to other services when this was needed. Where a referral was necessary, the type of care and treatment was explained to the patient and they were given a choice of other healthcare professionals who were experienced in undertaking the type of treatment required.

The practice had arrangements for emergency dental treatment out of surgery hours. This was displayed outside of the building, in the practice leaflet and on the practice information board. Patients we spoke with told us that they had never used this service but knew how to access it if they needed to.

Health promotion & prevention

The practice was aware of the Public Health England "Delivering Better Oral Health" guidelines and was proactive in providing preventative dental care as well as providing restorative treatments. Dental care records that we viewed illustrated that discussions were carried out on smoking cessation and eating a healthy diet where required and patients we spoke with told us that they had been encouraged to stop smoking.

The water supply in Kent does not contain fluoride and the practice offered fluoride varnish applications as a preventative measure for both adults and children. The practice advised patients on how to achieve good oral health and maintain it.

The practice asked new patients to complete a health questionnaire which included further information for health history. The practice then invited patients for consultation with the dentist.

Information and leaflets promoting good oral health were displayed in the waiting areas.

Staffing

The practice benefited from employing a range of experienced staff. Staff who were under training were supported by experienced and trained senior members.

Are services effective?

(for example, treatment is effective)

New staff underwent induction to ensure they understood how the practice operated and that they were competent in their role. Records of induction training confirmed this. All staff had received an annual appraisal. We looked at six staff files and found that their appraisals had covered performance, training and development needs which had been addressed.

Staff told us they felt supported and confirmed that training was available for them to undertake for both practice / patient specific needs, such as oral health training and to further their future development if they wanted to. Records viewed confirmed this. Staff said that the dentists at the practice were supportive and always available for advice and guidance.

We saw evidence that all staff had completed appropriate training to maintain the continued professional development required for their registration with the General Dental Council. This included medical emergencies in dental practices, infection control, child and adult safeguarding, dental radiography (X-rays), oral cancer and other specific dental topics.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients who had completed Care Quality commission (CQC) comment cards were complimentary about the care and treatment they received at the practice. Patients told us that the practice was welcoming and referred to all of the staff as caring, helpful and always willing to listen. Patients who attended the practice with their children told us that their children were treated in an age-appropriate way and were recognised as individuals.

Staff told us that there was no definition between patients who received treatment on the NHS and those treated privately with regard to the time spent with them and access to the practice.

During the inspection we observed members of the team dealing with patients on the telephone and at the reception desk. We heard the staff were polite and helpful.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. They said that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had documents that guided staff in order to keep patients' private information confidential. For example, the data protection policy statement and the confidentiality policy.

Dental care records were in both electronic and paper format. Paper records that contained confidential information were held in a secure way so that only authorised staff could access them.

Involvement in decisions about care and treatment

Patients we spoke with specifically commented on being involved in decisions about treatment and the professionalism of all staff at the practice.

We looked at dental care records and we saw recorded information about discussions and explanations provided to patients about the care and treatment they needed. This included different options and the risks and benefits of each option discussed. One of the dental nurses we spoke with described how important it was to give patients enough time to consider which treatment option they wished to commence. We saw that patients were provided with written treatment plans that explained the treatment required and outlined any costs they were required to pay. Staff told us that they rarely carried out treatment the same day unless it was considered urgent. This allowed patients to consider the options, risks, benefits and costs before making a decision to proceed.

We saw that patients were also given information leaflets in relation to certain treatments, so they could use these to inform their decision making. Patients we spoke with told us that if they had any concerns regarding payment, they could discuss these with the dentist and alternative treatment options were explored as a consequence.

Patients we spoke with reflected a common theme with regard to the dentists providing the most minimally invasive treatments. They told us that they had complete faith in the staff and that everything was provided or suggested in their best interests.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided both NHS and private treatment which patients could choose from depending on their circumstances. The practice provided information about all the types of treatment available and their costs, which were on display in the practice and in the practice leaflet.

Care and treatment was planned and delivered by trained, registered and qualified staff; this ensured people's safety and welfare. A detailed medical history was taken for each person; records demonstrated that this was updated at each consultation. Staff told us and we saw that there was a system that flagged up any health risks when the person's file was accessed. This indicated people with health conditions were given the most suitable treatment for their needs. We saw that where patients had a specific medical condition, this was routinely monitored before any treatment or examinations were conducted. For example, diabetes. Records viewed and patients we spoke with confirmed this.

Tackling inequity and promoting equality

Staff told us that translation services were available for patients who did not have English as a first language. We a saw notice, written in different languages, in the reception area informing patients this service was available.

There was access into the building via one of two ramps with a treatment rooms on each split level. There was also an accessible toilet which was spacious and had hand rails to support patients.

Discrimination was avoided when making care and treatment decisions. Interviews with clinical staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of each patient's age, gender, race and culture as appropriate. There was written guidance available for staff to refer to help them avoid discrimination when making care and treatment decisions. For example, the equality and diversity policy.

Access to the service

The practice was open from 8am to 5.30pm Monday to Fridays and 9am to 1pm on Saturdays.

Patients could book appointments by telephoning the practice or by attending the reception desk in the practice. Specific longer appointments were available for vulnerable patients and those with mental health conditions.

The practice aimed to provide same day emergency access during opening hours and provided an on call arrangement for when the practice was closed. Information about the out of hour's service was available in the practice, on the answer phone message, in the practice leaflet and on the patient information board. The practice also shared details on how to access the NHS emergency out of hours services.

Patients we spoke with and those who completed comment cards said they experienced few difficulties when making appointments and were happy with the continuity of care provided by Eastgate Dental Practice.

Concerns & complaints

The practice had a complaints process which was available in the practice leaflet as well as being posted on the patient information board. This contained information about relevant external bodies

that patients could contact about their concerns if they were not satisfied with how the practice dealt with them.

We looked at information available about comments and compliments and complaints. The information showed that no complaints had been received in the last 12 months. We looked at historic complaints made and saw that the practice had followed their complaints procedure. The principal dentist and practice manager told us they did not receive many written complaints because they responded quickly to any verbal complaints made. We were told that any verbal complaints received were recorded in the patients notes.

Patients we spoke with told us that they felt confident in raising any issues or concerns with the practice and where they had complained, this was dealt with promptly and effectively.

Are services well-led?

Our findings

Leadership, openness and transparency

The practice had a strong leadership structure which was led by the principal dentist. Staff were experienced, suitably qualified and worked closely as a team. We observed an effective team in a relaxed atmosphere. Staff told us that they felt supported and it was a good place to work andthat they could talk to the principal dentist about anything.

Staff meetings were held on a three monthly basis, or sooner if there were important issues to discuss. Minutes of meetings showed the team discussed the day to day running of the practice; topics included staffing issues, sickness, and premises maintenance, accidents and incidents, as well as complaints received.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

There was a clear staffing structure and staff were aware of their specific roles and responsibilities.

There were arrangements for identifying, recording and managing risks, and implementing mitigating actions. However, issues with the control and prevention of infection had not been identified and the fire risk assessment had failed to identify risks associated with not recording fire drills and evacuations. We raised these issues with the principal dentist, who subsequently sent us documentary evidence to show that these areas of risk had been addressed within the required timescale following our visit.

There was a variety of policies, policy statements and other documents that the practice used to govern activity. For example, the sharps injury policy, the adult and child protection policy statement as well as the radiation protection file. Staff had access to and had recorded that they had read and understood them.

We saw and discussed information about audits that had been carried out at the practice. We noted that there was a commitment to clinical governance and all aspects of the service provided was scrutinised through audit activity. The programme checked different areas of the service which included, but was not limited to, infection control, X ray equipment, the quality of X –rays and dental care records. There were records demonstrating that an infection control audit had been completed in May 2015. Records showed that the results of these audits had been discussed at staff meetings. The practice was able to demonstrate they had developed or implemented action plans to address issues identified by these audits.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients via the monthly NHS friends and family test. Results from the most recent months were very positive scoring between 95 to 100% of their patients being happy to recommend the practice to others.

The practice carried out a patient feedback survey every year. We looked at the most recent survey results. The overall consensus was that patients were satisfied with the dental care they had received. The practice also took into account the views of patients and those close to them via feedback from comment slips, which could be completed and posted in a secure box on the reception desk.

The practice gathered feedback from staff through staff meetings and appraisals. Staff told us they would not hesitate to feedback and discuss any concerns or issues with the principal dentist.

Management lead through learning and improvement

The practice recognised the value of developing the staff team through learning and development. We found that all staff had all undertaken the necessary learning to maintain their continued professional development which is a requirement of their registration with the General Dental Council (GDC). Staff were supported financially or with time off, in order to allow them to update and develop their knowledge and skills.

There was a culture of openness to formally reporting and learning from patient safety incidents.