Overall summary

We carried out an announced comprehensive inspection of Carver Barracks Dental Centre on 24 May 2017.

To get to the heart of patient’s experience of care and treatment we asked 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 formed the framework for the areas we looked at during the inspection.

Our findings were:

<table>
<thead>
<tr>
<th>Question</th>
<th>Action Required</th>
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<tr>
<td>Are services safe?</td>
<td>No action required ✓</td>
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<tr>
<td>Are services effective?</td>
<td>No action required ✓</td>
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<tr>
<td>Are services caring?</td>
<td>No action required ✓</td>
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<tr>
<td>Are services responsive?</td>
<td>No action required ✓</td>
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<tr>
<td>Are services well-led?</td>
<td>No action required ✓</td>
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Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

This inspection was led by a CQC inspector and supported by a dental specialist advisor.

Background to this practice

Carver Barracks Dental Centre is a single chair practice serving a population of 800 military personnel primarily consisting of two army units, both of which required a very high level of dental fitness to prevent dental morbidity in the field. The majority of patients were aged between 18 and 25. The dental team comprised a military senior dental officer, military practice manager and a civilian dental nurse.

How we carried out this inspection

We carried out a comprehensive inspection of this service. Carver Barracks Dental Centre had not been inspected by the CQC previously.

Prior to the inspection we reviewed information about the practice provided to CQC by the DMS.

The inspection was led by a CQC inspector and supported by a military dental specialist advisor.

On the day of inspection we collected 33 CQC comment cards filled in by patients. We did not get the opportunity to speak with patients directly because the dental centre was only providing emergency care on the day due to the inspection taking place.

During the inspection we spoke with the practice manager; the senior dental officer; dental nurse; a unit operations officer and the health and safety and infrastructure advisors for the station. We looked at practice systems, policies, standard operating procedures and other records which supported in relation to how the service was managed. We also checked the building, equipment and facilities.

Our key findings were:

- The practice was clean and equipment was well maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems for recording incidents, accidents and significant events.
- The practice had systems to help them manage risk.
- The practice had suitable safeguarding processes and staff knew their responsibilities for
safeguarding adults and young people.

- The practice had thorough staff recruitment procedures.
- The clinical staff provided care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients’ needs.
- The practice had effective leadership. Staff felt involved and supported and worked well as a team.
- The practice asked patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.

We identified the following notable practice, which had a positive impact on patient experience:

The practice was undertaking an oral health audit involving the completion of a structured questionnaire with each patient. The audit looked in detail at each patient’s history and current oral hygiene habits. Not only did the audit support with the identification of themes in relation to oral health need at the population level, it also provided each patient with bespoke advice on how to improve their oral hygiene. Feedback from patients suggested they valued the advice provided about oral hygiene.

The dental centre had developed good and effective relationships with the co-located medical centre. Where appropriate, the dental team referred patients to the medical centre for health promotion support, including smoking cessation and advice about alcohol use. An arrangement was in place for doctors to check a patient’s dental record when they attended for an appointment. If the patient was out-of-date for a dental check-up they were advised to call across to the dental centre to make an appointment. This had a positive impact on ensuring patients were receiving a dental assessment in a timely way and meant the dental centre was consistently meeting dental targets. In addition, both practice managers shared attendance at unit committee and quarter master meetings, and raised agenda items on behalf of each other, which demonstrated effective and efficient use of resources.

Dr John Milne MBE BChD, Senior National Dental Advisor
(on behalf of CQC’s Chief Inspector of Primary Medical Services)
Detailed findings

Our findings

We found that this practice was safe in accordance with CQC's inspection framework

Reporting, learning and improvement from incidents

Underpinned by policy and procedure, the practice used the standardised DMS-wide electronic system to report, investigate and learn from significant events, incidents and near misses. Staff were aware of their role in the reporting and managing of incidents, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager said there had been no significant events, near misses or incidents in the last 12 months.

The practice was informed by regional headquarters (RHQ) about the outcome of investigations into incidents and significant events in other dental practices. The practice manager gave an example of how a change to practice had been made in response to the findings and recommendations from an incident involving matrix bands in another practice.

The practice manager received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). They checked the CAS system regularly for updates and shared any relevant alerts with the staff at the monthly practice meetings. For example, an alert in relation to defibrillators was discussed at one of the practice meeting.

Reliable safety systems and processes (including safeguarding)

The senior dental officer (SDO) was the safeguarding lead for the practice. Staff knew their responsibilities if they had concerns about the safety of adults who were vulnerable due to their circumstances. A safeguarding policy and procedure was in place to provide staff with information about identifying, reporting and dealing with suspected abuse. The practice manager confirmed that the dentist always treated patients with the support of a dental nurse.

The safeguarding procedure was available in a prominent place for staff to quickly access. We were provided with evidence to confirm staff received safeguarding training at a level relevant to their role. The practice manager said the training was refreshed every three years. The practice had never had cause to report a safeguarding concern. A whistleblowing policy was in place. Staff were aware of how to report a concern in accordance with the policy and said they felt confident...
they could raise concerns without fear of recrimination.

We looked at the practice’s arrangements for safe dental care and treatment. These included risk assessments which were regularly reviewed. The practice followed relevant safety laws when using needles and other sharp dental items. The dentists routinely used rubber dams when providing root canal treatment in line with guidance from the British Endodontic Society.

A business continuity policy and disaster recovery plan was in place, which set out how the service would be provided if an incident occurred that impacted on its operation.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every two to three months. A record of this training was logged and the practice manager monitored it to ensure staff attendance.

Emergency equipment and medicines, including oxygen were available as described in recognised guidance. Staff kept records of the daily checks they undertook to ensure the required equipment and medicines were available, within their expiry date and that equipment was in working order.

Bodily fluids and mercury spillage kits were available, along with a first aid kit. The practice manager confirmed that the staff team had received first aid training.

Staff recruitment

The full range of recruitment records were held centrally at regional headquarters. The practice manager held some information so could demonstrate that all relevant safety and security checks had taken place at the point of recruitment. These included a Disclosure and Barring Service check to ensure staff were suitable to work with vulnerable adults and young people. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. The practice manager kept an electronic log of the dates when staff renewed their registration, along with a scanned copy of certificate of registration.

We looked at the recruitment record for a temporary member of staff recently recruited through an agency. It included all the relevant checks and confirmation that the member of staff had their own indemnity.

Monitoring health & safety and responding to risks

Organisation-wide health and safety policy and protocols were in place to support with managing potential risk. Staff were required to participate in health and safety training every two years and attendance at this training was monitored.

The station’s Safety, Health, Environment and Fire (SHEF) department was responsible for ensuring routine health and safety risk assessments of the premises. The practice manager also carried out their own checks of the premises and equipment. The practice manager said maintenance requests were dealt with in a timely way and any health and safety concerns were responded to promptly.
The SHEF department were responsible for the management of fire systems and a fire management plan was in place for the station. A fire risk assessment of the premises took place annually and was due to be refreshed in June 2017. We identified a gap in the fire evacuation procedure and the practice manager provided evidence shortly after the inspection to confirm this had been addressed.

Staff were required to attend SHEF fire training on an annual basis and attendance at this training was monitored to ensure staff participated. The last fire evacuation exercise took place in March 2017. The practice manager advised us that each Thursday the fire alarm was tested.

A Control of Substances Hazardous to Health (COSHH) file was maintained to ensure information on the risks from hazardous substances was available for staff. Risk assessments for each of the COSHH products were in place along with safety data sheets; information sheets about each hazardous product, including handling, storage and emergency measures in case of an accident. The practice manager reviewed the COSHH file annually to ensure it was up-to-date and took account of any new products introduced to the practice.

Infection control

An infection prevention and control (IPC) policy supported by protocols was in place at the practice. It followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. The practice manager was the dedicated lead for IPC and had completed relevant training for the role. They said the staff team received IPC training every six months. Records confirmed that staff completed IPC training as part of their continuing professional development.

The dental nurse demonstrated the sterilisation process for us, including the cleaning, checking, sterilising and storing instruments. The process was in line with HTM01-05. Records showed the equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturer’s guidance. The practice manager carried out IPC audits twice a year.

A management plan and protocols were in place to reduce the possibility of Legionella or other bacteria developing in the water systems. These procedures were in accordance with the Legionella risk assessment. The risk assessment was reviewed in April 2016 following the installation of two new air conditioning systems. The SHEF department carried out monthly safety checks of the relevant hot and cold water outlets each month. Six monthly water quality checks were also undertaken.

Environmental cleaning was carried out by an external company twice a day. The practice was clean when we inspected and patient’s feedback suggested a high level of satisfaction with the level of cleanliness at the practice. Environmental cleaning equipment was in accordance with national guidance, including how it was stored.

Arrangements were in place for the segregation, secure storage and disposal of clinical waste products, including amalgam, extracted teeth and gypsum.

Equipment and medicines

Equipment logs were maintained by the practice manager that kept a track of when equipment was due a service. Both clinical and non-clinical equipment had been serviced in the last 12 months and records were in place to support this. Staff carried out routine equipment checks in line with the manufacturer’s recommendations. A safety test of portable electrical appliances had
been undertaken in November 2016.

The practice had suitable systems for the safe management of medicines as described in current guidance. Prescription sheets were stored securely. Antibiotics were logged, checked and stored appropriately. Medicines requiring cold storage were refrigerated and the temperature of the fridge was monitored and recorded each day.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The practice was meeting current radiation regulations and had the required information in the radiation protection file. Local Rules were located in the radiation file and also alongside the X-ray machine they related to.

The dental records we looked at showed the dentists justified, graded and reported on the X-rays they took. In accordance with current guidance and legislation, the practice carried out X-ray audits. Clinical staff were up-to-date with dental radiography training and they had completed it as part of their continuous professional development.
Our findings

We found that this practice was effective in accordance with CQC’s inspection framework

Monitoring and improving outcomes for patients

We looked at dental records. They were detailed containing comprehensive information about the patient’s current dental needs, past treatment, medical history and treatment options. The diagnosis and treatment plan for each patient was clearly recorded. They showed a rigorous audit trail for patient choice and decision making.

The dentist assessed patients’ treatment needs in line with recognised guidance. For example, the dentist followed appropriate guidance in relation to the management of wisdom teeth and recall intervals between oral health reviews.

Feedback from patients indicated that their dental assessment and treatment was thorough, and they were briefed about what was happening at every stage of the treatment process.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. Dental records showed that oral health promotion was discussed with patients on an individual basis, including lifestyle habits. For example, referrals could be made to the medical centre for advice about smoking and alcohol cessation.

An oral health audit was ongoing that involved completing a structured questionnaire with individual patients to understand the needs of the patient population in relation to oral hygiene practice. The audit looked in detail at each patient’s history and current oral hygiene habits. Not only did this audit support the identification of themes in relation to oral health, it also provided each patient with bespoke advice on how to improve their oral hygiene.

Feedback from patients suggested that good advice was provided about oral hygiene. One of the feedback cards indicated the patient received advice about ways to improve their dental hygiene that they had previously been unaware of.

An oral health promotion stand was located in the waiting area and the practice manager said this was refreshed on a regular basis to include promote new topics, such as Smile Month, Stoptober and Mouth Cancer Awareness Week. The practice was in the process of developing a display showing the amount of sugar in various drinks. The practice manager said the staff team participated in the regular station health promotion fairs.
Staffing

Staff new to the practice had a period of induction based on a structured induction programme. We looked at the induction records for the most recently recruited member of staff and could see that it was a comprehensive process. We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Staff said they discussed training needs at their mid and end year annual appraisal. We saw evidence of completed appraisals. An organisational-wide electronic system was in place for the recording and monitoring of staff training and appraisal. The system provided alerts if staff were due to refresh training and the practice manager said they checked it weekly to see if any training was due.

The training staff were required to complete included safeguarding, equality and diversity, workplace safety, business continuity, IPC, medical emergencies and information governance. Staff said they were supported and encouraged to keep up-to-date with their continuous professional development.

The team was not working to the full staff complement as one of team had recently moved on and had not been replaced. In the absence of a hygienist/therapist, the senior dental officer carried out all dental treatment. Staff said appointments were planned to ensure the most effective and efficient use of staff time. They factored in the complexity of each clinical session along with instrument requirement, and the need for a sterilisation cycle to take place. It was clear the staff team were working efficiently and effectively as they were meeting the military dental targets. One of their strategies was to all take their annual leave at the same time and this was something they were happy to do. The practice manager was also a dental nurse and supported with the sterilisation process if the dental nurse was busy.

At the time of the inspection the population at risk (PAR) was 800. Staff advised us the PAR was due to rise to over 1000 soon. The senior dental officer said discussions were in progress with senior personnel to create another treatment room in the dental centre as it had been recognised additional staffing resources and facilities would be needed to meet the demand of the increased population.

Working with other services

Staff confirmed patients could be referred to a range of services if treatment was not provided at the practice. These services included referrals to military enhanced dental practices (practices providing additional services, such as sedation) and external referrals to a local NHS trust for oral surgery. A referral protocol was in place for suspected oral cancer under the national two week wait arrangements. This was initiated in 2005 by The National Institute for Health and Care Excellence (NICE) to help make sure patients were seen quickly by a specialist.

The practice manager maintained a log of all referrals made and they monitored the status of these on a regular basis, particularly to ensure urgent referrals were dealt with promptly. In addition, the practice had developed effective relationships with the co-located medical centre and referred patients if appropriate. The senior dental officer had an arrangement with doctors at the medical centre. If the doctor noted on the patient’s health records a dental check-up was overdue they would ask the patient to make a dental appointment before leaving the building. The practice manager said this arrangement worked well as it supported with identifying patients who needed dental input. It also contributed to the team meeting the dental targets set by the military.
**Consent to care and treatment**

Staff we spoke with understood the importance of obtaining and recording patient’s consent to treatment. They said they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. The dental records we looked at confirmed this. Mostly it was verbal consent taken from patients. For any oral surgery procedures full written consent was obtained. Feedback informed us that patients were satisfied they received clear information about their treatment and treatment options were discussed with them.

Staff had a good understanding of their responsibilities under the Mental Capacity Act (2005) should they need to treat adults who may not be able to make informed decisions.
Our findings

We found that this practice was caring in accordance with CQC’s inspection framework

**Respect, dignity, compassion and empathy**

Staff we spoke with were aware of their responsibility to respect people’s diversity and human rights. Patients commented positively about the practice in their feedback. They said staff were professional and understanding of their needs. They felt listened to and said their views were respected.

Patient’s feedback suggested staff were understanding and put them at ease if they were nervous about having dental treatment. A range of strategies were used to support with reducing anxiety. These included an extended appointment time, referral for cognitive behavioural therapy and a referral to an internal practice for conscious sedation.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas did not fully provide privacy when reception staff were liaising with patients. Staff said if a patient required more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it. Staff password protected patient’s electronic care records and backed these up to secure storage. Paper records were stored securely at the practice.

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed in the patient waiting area and available in the practice leaflet.

**Involvement in decisions about care and treatment**

Patient feedback suggested staff provided clear information to help with making treatment choices. The dental records clearly showed patients were informed about the treatment choices available and were involved in the decision making. Oral health information leaflets were available for patients.
Are services responsive to people’s needs? (for example, to feedback?)

Our findings

We found that this practice was responsive in accordance with CQC’s inspection framework

Responding to and meeting patients’ needs

Patient feedback suggested high levels of satisfaction with the responsive service provided by the practice, including urgent out-of-hours access.

The practice had an efficient routine appointment system to respond to patient need. Staff followed the principle that all regular serving military personnel are required to have a periodic dental inspection every 6 - 24 months depending on a dental risk assessment or recall period. The practice manager said they conducted regular searches on the dental electronic system to check that patients had an appointment with the dentist in accordance with their recall time.

Promoting equality

An access audit as defined in the Equality Act 2010 was not available for the premises. An access audit forms the basis of a plan to support with improving accessibility of premises, facilities and service for patients, staff and others with a disability. The unit operations officer and health and safety advisor for the station said an overall access audit was not in place but an assessment had been carried out and reasonable adjustments made to facilitate access in relation to the specific needs of a person who used the dental centre.

A hearing loop was not available as this had not been identified as a need for the population at the station. Staff had access to a translation service should the need arise. Patients could be referred to another dental military practice if they had a preference to be treated by a female dentist.

Access to the service

The practice displayed its opening hours in the premises. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. They were aware of how to access the out-of-hours dental services.

An hour slot was allocated for emergencies (referred to as sick parade) in the morning. A rota was in place for access to an on-call dentist out-of-hours. This rota was available at the guardroom and was also held by heads of department.

Concerns and complaints

The SDO was responsible for managing complaints. A complaints policy and protocol was in place that provided guidance for staff on how to handle a complaint. Staff had received training in complaints so were familiar with the policy and their responsibilities. Processes were in place for documenting and managing complaints. The practice manager confirmed that no complaints had
been received the last 12 months.
Our findings

We found that this practice was well-led in accordance with CQC's inspection framework

Governance arrangements

The senior dental officer had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service.

The practice manager provided us with an overview of the governance arrangements for the dental centre, including lines of reporting and accountability. The practice manager completed a report every four weeks for regional headquarters that provided feedback on a range of clinical and non-clinical activity undertaken for the month. The Common Assurance Framework (CAF), a structured self-assessment internal quality assurance process, formed the basis for monitoring the quality of the service. The practice manager in collaboration with the dental team completed the CAF and the practice manager kept it under review and updated it as appropriate. The Principal Dental Officer (PDO) for the region had access to the CAF and carried out unannounced spot checks. Using the CAF framework, the PDO coordinated a bi-annual health governance assurance audit of the practice. If required, an action plan was developed following this and was then updated by the by the practice manager as actions were completed. It was accessible on the system for the PDO to monitor.

The practice manager attended regional practice manager meetings. At these meetings significant events, new guidance, learning from incidents and any changes were shared.

The practice manager provided an overview of the dental centre’s relationships and engagement at station level. They represented the SDO at the monthly unit committee meetings. These meetings mainly looked at the statistics regarding the dental fitness of military personal, with the focus on dental targets and whether they were being met. The practice manager also attended weekly quarter master meetings that included agenda items, such as dental fitness of the population, infrastructure, maintenance, equipment and staffing. In addition, they attended the six monthly health and safety meetings for the station.

The dental centre team had a good working relationship with the co-located medical centre team. Both practice managers shared operational activity if appropriate, demonstrating an efficient and effective use of resources. For example, if the dental centre was short of staff then the practice manager from the medical centre attending the quarter master and unit health committee meetings raised any issues on behalf of the dental centre and provided feedback. This arrangement was reciprocal. The practice manager also attended the medical centre practice meetings, particular if it related to the infrastructure or shared resources.

A framework of organisation-wide policies, procedures and protocols were in place. In addition, there were dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff were familiar with these and they made reference
to them throughout the inspection. Risk management processes were in place to ensure the safety of patients and staff working at the dental centre. They included risk assessments relating to the environment, equipment and lone working. A range of checks and audits were in place to monitor the quality of service provision and inform the CAF.

We looked at communication systems within the practice. The main forum for sharing information was through the monthly practice meetings. We looked at a range of meeting minutes and noted they included standard agenda items, such as equipment, SHEF, governance, significant incidents, staff training and complaints. It was clear that the outcome of investigations, audit and other quality checks was shared with the staff team. MHRA and CAS alerts were also discussed at the meetings. The practice manager provided feedback to the staff team from the various meetings they attended.

Information governance arrangements were established and staff were aware of the importance of these in protecting patient’s personal information. Each member of staff had their login password to access the electronic systems. They were not permitted to share their passwords with other staff. Paper records were stored securely.

**Leadership, openness and transparency**

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff said the culture was open and transparent, and they would be confident raising any concerns. They told us they were treated with respect both at all levels of the organisation and felt any concerns they may raise would be listened to and acted on appropriately. It was evident from observation and discussions that the team worked well together and valued each other’s contribution.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were evident at the practice. These included a programme of audit. Infection prevention and control audits were conducted every six months. The dentist completed a radiology audit every six months. Other audits undertaken included a complaints audit and oral hygiene audit. A prescribing audit was undertaken for the region and the dental centre contributed to it. The practice had records of the results of these audits, including the action plans and improvements made. For example, a request for keyboard covers was submitted following an IPC audit.

The practice manager said that significant findings from audits in other dental practices were shared across all dental practices.

We could see from the monitoring system that staff were up-to-date with their mid and end year appraisals. Each member of staff had a personal development plan resulting from their appraisal. The practice manager had a process in place to monitor that staff were up-to-date with their continuing professional development.

The staff said they participated in a peer review every six months year with other dental professionals within region. The last peer review took place in April 2016 and one of the topics discussed included the electronic system for reporting significant events, incidents and near misses.
Practice seeks and acts on feedback from its patients, the public and staff

A process was in place to seek patient feedback. We looked at the last survey and noted the feedback received about the practice was positive. A suggestion box was located in the waiting area. Suggestions were acted on. For example, tinted goggles were replaced with clear goggles following a suggested request by a patient.

A system was in place for staff to provide feedback and this was organised through the Defence Medical Services.