We carried out an announced comprehensive inspection of HMS Drake 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:**

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<th>Are services safe?</th>
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<td>Are services responsive?</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 two dental specialist advisors.

Background to this practice

HMS Drake Dental Centre was providing a service to an operational and deployable population of 3700; most aged from 18-50 years. The centre is located within HM Naval Base Devonport and is co-located in a building with occupational health. The centre has eight surgeries; seven on the first floor and one on the ground floor to accommodate patients with mobility needs. The full range of primary dental care is offered, including urgent same day appointments and an out-of-hours on-call service. The department has access to enhanced practitioners for specialised dentistry. Patients requiring oral surgery are referred to the local NHS hospital. The department is a foundation dentist training practice.

The dental centre also provided a portable dental unit that could fly to ships along with a staff team to treat personnel deployed.

The staff team consisted of a mixture of military and civilian personnel including, five dentists, two hygienists and 12 support staff. An endodontic enhanced practitioner and a foundation dentist were also working at the practice.

How we carried out this inspection

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

On the day of inspection we collected 38 CQC comment cards filled in by patients and spoke with two other patients. This information gave us a positive view of the practice.

During the inspection we spoke with the practice manager, the regional practice manager, the practice supervisor, the senior dental officer, two dentists, the endodontist, a hygienist and two dental nurses. We looked at practice systems, policies, standard operating procedures and other records in relation to how the service was managed. We also checked the building, equipment and facilities.

Our key findings were:

- The practice used a DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- The practice had systems to support the management of risk, including clinical and non-clinical risk.
• Equipment was well maintained.
• The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and young people.
• Staff were appropriately recruited and received a comprehensive induction when they started work at the practice.
• 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 patient’s 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 had an effective system in place to deal with complaints.
• Medicines and life-saving equipment were available in the event of a medical emergency.
• The practice was not working in accordance with best practice guidelines for the decontamination of dental instruments.

We found areas where the practice could make improvements. CQC recommends that the practice:

• Review the infection control procedures and protocols 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 staff training and monitoring arrangements for medicines for managing medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK) and the General Dental Council (GDC) standards for the dental team.

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

Are services safe?

Our findings

We found that this practice was not safe in accordance with CQC’s inspection framework

The shortcomings did not have a significant impact on the safety and quality of clinical care.

Reporting, learning and improvement from incidents

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 provided two reported examples of significant events involving X-ray equipment. They described how the events were investigated and changes made as a result of the investigation. Staff we spoke with were aware of these two examples and the changes made as a result. We noted that incidents and significant events were a standard agenda item on the practice meetings held every two weeks.

The practice was informed by regional headquarters about the outcome of investigations into incidents and significant events in other dental practices. We were provided an example of the learning and action taken in response to a significant event that occurred elsewhere. The practice manager advised us they received monthly and quarterly clinical directives that reported on the outcome of significant events regionally and nationally, including trends.

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). Relevant alerts were discussed at practice meetings. Staff said they received emails informing them of any relevant alerts and confirmed that alerts were discussed at the practice meetings held every two weeks. The practice manager had a system in place to confirm staff had received the alerts and read them.

Reliable safety systems and processes (including safeguarding)

The senior dental officer was the safeguarding lead for the practice. Staff were aware of their responsibilities if they had concerns about the safety of young people and 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 safeguarding procedure was accessible to staff. We were provided with evidence to confirm staff received both child and adult 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 and staff accurately described what they would do if they wished to report in accordance with the policy. They said they felt confident they could raise concerns without fear of recrimination.

The practice manager confirmed that the dentists always treated patients with the support of a dental nurse. The hygienists did not have another member of staff in the surgery when treating patients. A risk assessment was not in place to support this arrangement. However, the practice manager provided us with a risk assessment shortly after the inspection. We noted it took account of the action the hygienist should take in the event of a medical emergency.

We looked at the practice’s arrangements for safe dental care and treatment. These included risk assessments that 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 where the emergency drugs, oxygen and defibrillator were kept. The emergency trolley was located in the corridor during the day and stored in a locked room at night. There was a specific way to open the trolley. A member of staff did not know how to open it and we highlighted this to the practice manager.

We asked staff who they would contact in the event of a medical emergency. Not all key parties were not included in the responses we received. We raised this with the practice manager and senior dental officer and discussed whether it would be useful for a briefing about what to do in the event of a medical emergency to be located next to telephones.

Staff had completed training in emergency resuscitation, which was provided at the twice yearly regional training days. A record of simulated training scenarios also took place in various areas of the practice. The surgery on the ground floor was mainly used as a shore side capability for a ship's dental practice when the vessel was alongside. However, it was also used on occasion to treat patients who were unable to use the stairs due to a disability, chronic condition or injury. A simulated medical emergency had not been undertaken in the downstairs surgery. We highlighted to the senior dental officer and practice manager that this would be a useful exercise in order to test response times.

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. The emergency drugs were in-date in the upstairs medicine fridge. We found the emergency drug (Glucagon) held in the downstairs surgery had not had its expiry date amended to reflect that it was not stored in a fridge. The drug was in date in accordance with the manufacturer’s expiry date but should have been replaced because it had not been stored in a fridge. This had not been
noted in any of the checks undertaken. In addition, we observed no signage on the door to indicate the oxygen was stored there and we highlighted these issues to the practice manager.

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 the regional headquarters. The practice manager had access to the DMS-wide electronic system so could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The system also monitored each member of staff’s registration status with the General Dental Council (GDC). The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

All the staff we spoke with said the staffing levels at the practice were sufficient to ensure patient’s needs were met in a timely way. Feedback from patients suggested the service provided was both timely and efficient. We asked how the practice managed when a staff team was sent to provide dental care on a ship. Staff said this happened regularly and involved advance planning to ensure staff cover was sufficient at the dental centre.

**Monitoring health & safety and responding to risks**

The practice manager was the health and safety lead for the practice and had completed relevant training for the role. Organisation-wide health and safety policy and protocols were in place to support with managing potential risk. The practice manager conducted a health and safety inspection every six months. Records demonstrated that staff were up-to-date with health and safety training. Training was provided at induction and through on-line courses. As health and safety was a standard agenda item, updates were provided to staff at practice meetings.

The station’s Safety, Health, Environment and Fire (SHEF) department was responsible for ensuring routine health and safety risk assessments of the premises. Evidence was in place showing a health and safety audit was carried out in November 2016. The practice manager said the SHEF team dealt with maintenance requests and these were dealt with in a timely way. Any health and safety concerns were responded to promptly.

There had been problems with the building including rising damp. We noted a damp odour to the ground floor and there was evidence of damp in the accessible toilet. The senior dental officer advised us that the dental centre was due to relocate to a new building but this had been deferred to 2020. In the meantime improvements had been made to the building to extend its life. These included a new roof and new windows.

The SHEF department was 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 had been undertaken in February 2014. Measures were in place to minimise the risk of fire and these included weekly checks of firefighting equipment and environmental measures, such as fire doors. The fire alarm was tested weekly. The practice manager said that a fire evacuation exercise had taken place recently. Records showed that staff were up-to-date with fire training.

A Control of Substances Hazardous to Health (COSHH) file was maintained for the station to
ensure information on the risks from hazardous substances was available for staff. The practice manager had the lead for COSHH and had completed a COSHH course. 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 COSHH file was last reviewed in March 2017.

**Infection control**

An infection prevention and control (IPC) policy supported by protocols were in place for the practice and these were located in the surgeries. It followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. A member of staff was the dedicated lead for IPC and had completed relevant training for the role. The staff team were up-to-date with IPC training and records confirmed staff completed IPC training as part of their continuing professional development. IPC updates were provided at the twice yearly regional training days. The IPC lead also facilitated regular updates and learning at the practice.

The practice did not have a central sterilisation unit and the sterilisation of dental instruments took place in the surgeries. The facilities were not suitable and were not in accordance with HTM 01-05. We observed chips in the cabinetry and holes in the walls and skirting in at least two of the surgeries. Some surgeries were cluttered and messy with no clearly labelled clean and dirty zones.

We checked the sterilisation equipment and dental instruments and found the expiry date was not always recorded on the sterile pouches containing instruments. Furthermore, we noted the sterile date on some pouches had expired and some of the materials held in the surgeries were out-of-date. A log was not in place to record when the solution for the ultrasonic bath was changed and the first testing strip of the day was not retained for the old steriliser if it needed to be used. In addition, the biofilm and protein test results were not retained as evidence that testing had taken place. Adequate handwashing materials were not available in all of the staff toilets.

We were advised by the IPC lead that the surgeries were checked each Friday and IPC audits were undertaken twice a year. Neither of these monitoring processes had identified the issues we found with the infection control arrangements.

Although a Legionella risk assessment was not seen on the day of inspection, a member of staff from the SHEF department confirmed it had been completed, including a management plan to reduce the possibility of Legionella or other bacteria developing in the water systems. An external contractor 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 feedback did not highlight any concerns with the cleanliness. 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 to be serviced. An equipment service audit was undertaken annually. Staff carried out routine equipment checks in line with the manufacturer’s recommendations. A safety test of portable electrical appliances had been undertaken.

The practice had suitable systems for the safe management of medicines as described in current guidance. Prescription sheets were stored securely. Antibiotics for use out-of-hours were in-date, logged, checked and stored appropriately. Medicines requiring cold storage were refrigerated and the temperature of the fridge was monitored and recorded each day. We noted it was excessively hot in the equipment and material storeroom. The temperature of the room was not being monitored despite some materials requiring storage within a defined temperature range. We highlighted this to the practice manager at the time of inspection.

**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 in each of the surgeries.

The dental records we looked at showed that 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 twice a year. 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 a range of dental records completed by the dentists working at the practice. The records 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 and showed that treatment options were discussed with the patient. 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. We were advised that recall arrangements were also linked to a patient's operational cycle, including deployment schedule.

Feedback from patients indicated that their dental assessment and treatment was thorough, and they found it helpful to be informed about what was happening with a rationale given for the treatment being undertaken.

We looked at the military dental fitness targets and noted some were below target. The senior dental officer explained that the population was not static due to operational deployment. The dental fitness targets were monitored closely and if necessary the portable dental unit and a staff team was deployed to provide dental treatment on ships.

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 hygiene advice was given to patients on an individual basis, including discussions about lifestyle habits. An audit was in place to determine the alcohol intake and drinking habits of patients. Referrals could be made to other health professionals, such as referrals for advice about smoking and alcohol use. The application of fluoride varnish was an option the dental professionals considered if necessary but advised us that is was not often used now given the population age.

The hygienist showed us examples in the dental records of how they mapped the progress and improvements in oral hygiene for individual patients. We looked at one record in detail and could clearly see how the patient’s oral health had improved over time.

The practice supported a range of oral health promotion campaigns, including Smile Month, Stoptober and Mouth Cancer Awareness Week. An oral health promotion stand was located in the waiting area and this was refreshed on a regular basis to include promotion of new topics. The dental team participated in the regular health and wellbeing promotion fairs held at the station.
practice also placed promotional posters in social facilities across the station to raise awareness of oral health.

A children’s day nursery was located at the station and children had visited the dental practice. In addition, the hygienist visited the nursery 12 months ago to talk through with the children how to clean and look after their teeth. The practice also facilitated oral health promotion sessions for school leavers and university graduates who were visiting the station as part of their intention to join the navy.

**Staffing**

The practice manager advised us that staff new to the practice, including locum staff had a period of induction based on a structured induction programme that was tailored to HMS Drake. The induction records for a locum member of staff demonstrated a comprehensive process that took account of matters, such as health and safety, radiation, fire, complaints, IPC and operational systems.

We looked at the organisational-wide electronic system that recorded and monitored staff training and appraisal. Through this we confirmed staff were up-to-date with the training they were required to complete. The training included safeguarding, equality and diversity, workplace safety, business continuity, IPC, medical emergencies and information governance. Furthermore, the system showed clinical staff were undertaking the continuous professional development required for their registration with the General Dental Council.

**Working with other services**

Staff confirmed patients could be referred to the endodontist based at the practice. They could also refer patients to a range of services if the treatment required 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 monitored the status of these on a regular basis, particularly to ensure urgent referrals were dealt with promptly.

**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. Verbal consent was taken from patients for routine treatment. For more complex procedures, full written consent was obtained. Feedback informed us that patients were satisfied that 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. Staff said they had recently received training in consent.
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 favourably about the practice in their feedback. They said visiting the practice was a good experience and they found the staff professional, caring and informative.

Patient feedback indicated staff were understanding and put them at ease if they were nervous about having dental treatment. Staff advised us that in the first instance the patient would be invited to a non-clinical area of the practice to talk through their anxieties. If necessary other strategies for reducing anxiety could be considered, such as a referral for cognitive behavioural therapy or referral to an enhanced practice for conscious sedation.

Staff were aware of the importance of privacy and confidentiality. The waiting room was separate from the reception area so the likelihood of patients being overheard at reception was minimal. 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 and leaflets were available for patients.
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 a routine appointment system to respond to patient need. Staff followed the principle that all regular serving military personnel were required to have a periodic dental inspection every 6 - 24 months depending on a dental risk assessment or recall period. The practice manager said one of the staff was responsible for conducting regular searches on the dental electronic patient record system to check that patients had an appointment with the dentist in accordance with their recall time. Since introducing a text reminder service for appointments, the practice manager said there had been a 20% drop in patients failing to attend appointments over the last 12 months.

Promoting equality

An access audit as defined in the Equality Act 2010 was not available for the premises. This audit forms the basis of a plan to support with improving accessibility of premises, facilities and services for patients, staff and others with a disability. Although the population of wheelchair users and patients with disabilities was very low, reasonable adjustments were in place. For example, there was step-free access to the building and an accessible toilet to the ground floor. A surgery with widened access to accommodate wheelchair users was available on the ground floor. This surgery was used by a few patients who were unable to use the stairs.

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. The practice manager told us there was a need for this service as military personnel from other countries undertaking joint exercises with military personnel at the station sometimes required treatment at the practice. Patients could choose the gender of their dentist if they had a preference.

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.

Each morning and afternoon 30 minute slots were kept free (referred to as sick parade) for patients with an emergency need to be seen. If patients had an urgent need outside of that time staff said the practice would find a way to accommodate them so they are seen on the same day. A rota was in place for access to an on-call dentist out-of-hours within the region.
Concerns and complaints

The practice manager was responsible for managing complaints. A complaints policy and flowchart 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 both verbal and written complaints were taken into account in the process.

One complaint had been received in the last 12 months and they had been managed effectively. Changes had been made to a protocol as a result of the outcome of the investigation into the complaint and this had been shared with staff at a practice meeting.
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. A practice supervisor was in post that deputised for the practice manager and provided a clinical lead for the nursing team.

Through discussions with staff, we were provided with an overview of the governance arrangements for the dental centre, including lines of reporting and accountability. The practice manager provided a report to regional headquarters (RHQ) each month that reported on a range of clinical and non-clinical statistics and activity. 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 senior dental officer completed the CAF and the practice manager kept it under review and updated it as appropriate. An update in the form of a progress report on the CAF and associated action plan was submitted to RHQ each quarter. We noted the CAF was last updated in March 2017 and the practice achieved a score of 98%.

The Principal Dental Officer (PDO) for the region carried out spot checks of the CAF. Using the CAF framework, the PDO coordinated a biennial health governance assurance audit of the dental centre. If required an action plan was developed following this and was then updated by the practice manager as actions were completed. It was accessible on the system for the PDO to monitor.

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 clinical practice, the environment, equipment and lone working. A range of checks and audits were in place to monitor the quality of service provision.

The practice manager provided an overview of the dental centre’s relationships and engagement at station level. The senior dental officer attended monthly meetings with the Captain of the Base and other senior personnel to provide an update on matters, such as the dental fitness of the population, the infrastructure, equipment and staffing arrangements. The Captain of the Base along with representatives from other departments also carried out quarterly monitoring visits to the dental centre.

We looked at communication systems within the practice. The main forum for sharing information
was through the two weekly practice meetings. We looked at previous meeting minutes and noted they included standard agenda items, such as equipment, SHEF, governance, significant incidents, staff training and complaints. 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, including the six monthly practice manager regional meetings.

The practice manager shared with staff the quarterly clinical operational directives they received from RHQ. We looked at recent directives and noted they provided updates on issues, such as staffing levels and CPD.

Information governance arrangements were established and staff were aware of the importance of these in protecting patient 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 their responsibilities in relation to duty of candour requirements. The practice manager provided an example of when they had been open and honest with a patient, offering an apology to the patient when an incident occurred during treatment. This had also been effectively managed through the incident reporting process.

Staff said the culture was open and transparent, and they would be confident raising any concerns. They told us they were treated with respect 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 valued each other’s contribution and worked well together.

One afternoon each week the practice closed and staff participated in ‘adventurous training’ that could involve a variety of recreational and/or physical fitness activities. Staff said they enjoyed these times as it supported with team building.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were evident at the practice. A programme of audit was in place including, on a six monthly basis, IPC, radiology and health and safety audits. Other audits included complaints, fire equipment and dental records. The dental records audit took account of patient recall. An audit was also undertaken of failure to attend appointments (FTA). Prescription audits were conducted at regional level. The practice had records of the results of these audits, including the action plans and improvements made. For example, as a result of the FTA appointment a mobile phone was acquired to provide patients with a text reminder of their appointment. A further example involved a review of the appointment system leading to an improvement in efficiency.

Given our findings in relation to infection control and decontamination, we queried the effectiveness of the IPC audit as it had not identified the issues we found through the inspection.

Staff received mid and end of year annual appraisal. The senior dental officer facilitated all the appraisals for civilian staff. We saw evidence of completed appraisals.

The dentists participated in a peer review meeting each month with other dental professionals.
within region. Learning days were held regularly at the practice for staff and it contributed towards staff CPD. Recent examples included sessions on radiation and medical emergencies.

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