We carried out an announced comprehensive inspection of Dental Centre Chester on 28 February 2019.

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>
</tr>
<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 Defence Medical Services Regulator’s office.

This inspection was led by a CQC inspector and supported by a specialist military dental officer advisor and a dental practice manager/nurse advisor.

Background to this practice

Located on the outskirts of Chester, Dale Barracks Dental Centre is a two-chair practice, co-located with the medical centre, providing routine dental care to a military population of 695 mostly male patients aged 18 to 40 years old. The demographic of the population comprises approximately 70% infantry soldiers, who are frequently deployed, and 30% from neighbouring units parented by the barracks.

The centre has a mix of military and civil service staff. An acting Senior Dental Officer is in post whilst the Dental Officer (DO) receives their induction. The DO is taking over responsibility of the practice in the upcoming weeks. The acting SDO assumed accountability for the quality of dental care provided at this centre and we interviewed them as part of our inspection.

An acting military practice manager is in post whilst the recruitment process is underway to employ a civilian practice manager. The practice employs one dentist, two full time civilian dental nurses and a part time hygienist (two days per week). There are no additional administrative or reception staff at this practice. The dental centre is open Monday to Thursday 08:00 to 12:30 and 13:00 to 16:30 and on Fridays from 08:00 to 12.30. The practice provides an emergency service during working hours and when the practice is closed. Patients can be referred internally and to the local NHS Trust for treatment not provided at the dental centre.

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the interim practice manager, the senior dental officer, one dentist 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.

On the day of inspection, we collected 46 CQC comment cards completed by patients prior to and during the inspection. We also spoke with three patients who were attending the dental or medical centre for an appointment. All the feedback from patients was positive.

Our key findings were:
The practice used a DMS-wide electronic system for reporting and managing incidents, accidents and significant events.

Systems were in place to support the management of risks.

Suitable safeguarding processes were established and staff knew their responsibilities for safeguarding adults and young people.

Staff were appropriately recruited and received an induction when they started work at the practice.

The clinical staff provided care and treatment in line with current guidelines. Clinical notes were good.

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 asked patients for feedback about the services they provided and made improvements to the service based on the feedback.

There was a system in place for managing complaints.

Medicines and life-saving equipment were available in the event of a medical emergency.

Infection control guidelines were being followed and standards met.

Staff were providing preventive care and supporting patients to ensure better oral health.

There were good information governance arrangements in place.

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

• Review the premises and facilities to provide an accessible environment that minimises risks for the patients and staff.

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

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

Reporting, learning and improvement from incidents

The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events and incidents. All staff had access to the system to report a significant event. Staff were clear in their understanding of the types of significant events that should be reported and understood how to report an incident, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice maintained a log of significant events, including the action taken and lessons learnt. The log identified that six significant events had been reported in the last 12 months. Significant events had been discussed at practice team meetings and staff we spoke with confirmed what they had learned.

The practice manager was informed by Regional Headquarters (RHQ) about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). The MHRA and CAS alerts received were logged and saved and any required action undertaken. As a standard agenda item, they were discussed at practice meetings.

Reliable safety systems and processes (including safeguarding)

The acting senior dental officer (SDO) was the safeguarding lead for the practice. All members of the staff team had completed level two child safeguarding training but evidence was not available during the inspection to show they had completed adult safeguarding training appropriate to their roles. The following day we were sent certificates to show all staff had undertaken and successfully passed adult safeguarding training.

Staff we spoke with 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 bespoke safeguarding policy and procedure was in place and contained the local contact details needed to appropriately signpost staff who needed to raise a concern. Staff told us that they could approach the SDO if they identified and needed to report suspected abuse. Practice staff
understood the importance of working closely with welfare teams and chain of command and recognised the unique vulnerabilities of young service personnel in their care.

The dentist was always supported by a dental nurse when assessing and treating patients. Where staff worked alone at the practice, there was a lone working policy in place to guide staff. A whistleblowing policy was in place and available to staff. They could describe what they would do if they wished to report in an incident.

We looked at the practice’s arrangements for safe dental care and treatment. These included risk assessments. The practice was following relevant safety legislation when using needles and other sharp dental items. A needle stick injury policy was available in all surgeries.

The dentist routinely used rubber dams when providing root canal treatment in line with guidance from the British Endodontic Society. They also used a rubber dam for some other complex treatments, such as restorative procedures. On very rare occasions, a parachute chain was used to protect the airway.

A comprehensive business resilience 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**

A civilian nurse maintained oversight of the defibrillator and emergency drugs kit. All staff were aware of medical emergency procedure and knew where to find medical oxygen, emergency drugs and equipment. Records identified that staff were up-to-date with training in managing medical emergencies, including emergency resuscitation and the use of the AED (automated external defibrillator). Simulated emergency scenarios were used to provide practical learning. An AED was available in the medical centre which is in the same building and although this was safe some discussion was had about making its positioning more favourable. Daily checks of the medical emergency kits were recorded and demonstrated that all items were present and in-date.

The medical emergency kit was located in the corridor outside the surgeries during working hours and then secured in a surgery when the practice was closed, including during the lunch hour. Signage was in place to identify the location of the medical oxygen. A first aid kit, bodily fluids and mercury spillage kits were available. Training records confirmed staff were up-to-date with first aid training.

**Staff recruitment**

The full range of recruitment records for permanent staff was held centrally. 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 an enhanced Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in line with requirements.

The regional clinical operations team monitored each member of staff’s registration status with the General Dental Council (GDC). The SDO confirmed all staff had professional Crown indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
Monitoring health & safety and responding to risks

A number of local health and safety policy and protocols were in place to support with managing potential risk. The fire risk assessment was comprehensive and included risks and contingencies. Staff received annual fire training and evacuation drills were scheduled. Fire alarms were tested weekly. Portable appliance testing had been carried out in line with policy. A COSHH (Control of Substances Hazardous to Health) risk assessment had been undertaken, along with routine environmental checks to ensure that the building was safe for patients and staff.

Infection control

The practice had an infection prevention and control policy and procedures. Staff followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

Decontamination of dental instruments took place in the surgeries as there was no CSSD, (central sterile services department). These areas were arranged and organised to support the safe decontamination of dental instruments. Routine checks were in place to monitor that the ultrasonic bath and autoclave were working correctly.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers’ guidance.

The practice had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected. The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We saw that the waiting area and reception area was carpeted. This issue had been raised, was on the risk register and a request for new flooring had been made.

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

Equipment and medicines

Equipment logs were maintained to keep a track of when equipment was due to be serviced. Autoclaves had been serviced and replaced as necessary. All other routine equipment checks, including clinical equipment, were in-date and in accordance with the manufacturer’s recommendations. A safety test of portable electrical appliances had been completed.
Prescription sheets were numbered and stored securely. Antibiotics were not held at the practice. There were reliable systems for the appropriate and safe handling of medicines. There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required. The dentist was aware of current guidance with regards to prescribing medicines. Medicines that required cold storage were kept in a fridge, the temperature of which was checked twice daily. Nursing staff knew what to do if temperatures fell outside safe parameters and we saw this had been effectively practised recently when temperature fluctuations were identified. We saw that appropriate actions had been taken to rectify this and ensure patient safety.

**Radiography (X-rays)**

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The required information in relation to radiation was located in the radiation protection file. A Radiation Protection Advisor and Radiation Protection Supervisor were identified for the practice. Signed and dated Local Rules were displayed in each surgery, along with safety procedures for radiography. Evidence was in place to show equipment was maintained every three years. Staff requiring IR(M)ER (Ionising Radiation Medical Exposure Regulations) training, had received relevant updates.

To corroborate our findings, we looked at range of patient’s dental care records. They showed the dentist justified, graded and reported on the X-rays they took. In accordance with current guidance and legislation each dentist carried out an annual radiology audit.
Our findings

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

Monitoring and improving outcomes for patients

Patients’ treatment needs were assessed by the dentist in line with recognised guidance. For example, wisdom teeth management was conducted in line with National Institute for Health and Care Excellence (NICE) guidelines. Treatment was planned in accordance with the BPE (basic periodontal examination - assessment of the gums) and caries (tooth decay) risk assessment. The dentist also followed appropriate guidance in relation to recall intervals between oral health reviews. Feedback from patients indicated that the assessment and treatment they received was comprehensive and effective.

We looked at patients’ dental records to corroborate our findings. 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. Patients completed a detailed medical and dental history form at their initial consultation and this was verbally checked for any changes at each subsequent appointment.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure better oral health. Dental records showed that lifestyle habits of patients, such as smoking and drinking, were included in the dental assessment process. An alcohol consumption audit was completed with all patients. Oral hygiene advice was given to patients on an individual basis, including discussions about lifestyle habits. The application of fluoride varnish and the use of fissure sealants were options the clinicians considered if necessary. Equally, high concentration fluoride toothpaste was recommended where appropriate. Patients were receiving care in accordance with their need. The enhanced skills of dental nurses (oral health education, application of fluoride varnish) were not yet being utilised to their maximum but this was something the practice were considering for the future.

Referrals could be made to other health professionals, such as referrals to the medical centre for advice about smoking, diet and alcohol use. A hygienist provided a service to patients two days each week. This was sufficient to proactively meet the needs of the population at risk.

The dental team participated in the health and wellbeing promotion fairs held at the barracks. The SDO attended unit health committee meetings with unit commanders to provide updates on the military dental targets and review the status of failed attendance at dental appointments (referred to as FTAs). Oral health promotion matters were also discussed, such as the uptake of smoking cessation.
Oral health displays were evident in the patient waiting area and on the stairs. Staff said the displays were refreshed on a regular basis and they often targeted to population need and/or seasonally activities, such as Mouth Cancer Awareness.

**Staffing**

Staff new to the practice had a period of induction that included a generic programme and induction tailored to the dental centre. Our review of induction records and discussion with staff indicated that induction programmes had been completed, prior to clinical work being undertaken by new staff members.

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. The system showed clinical staff were undertaking the continuing professional development (CPD) required for their registration with the General Dental Council.

**Working with other services**

The practice could refer patients to a range of services if the treatment required was not provided at the practice. For example, referrals to Chester Hospital for oral surgery. Staff were aware of the referral protocol 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. A referral log was maintained and this was checked regularly to ensure urgent referrals were dealt with promptly, and other referrals were progressing in a timely way.

**Consent to care and treatment**

Staff 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 care 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 very satisfied that they received clear information about their treatment and that treatment options were discussed with them. Staff had received training in the Mental Capacity Act (2005).
Our findings

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

Respect, dignity, compassion and empathy

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people’s diversity and human rights. Patients commented positively that staff were helpful and kind. We saw that staff treated patients with the upmost respect and were patient and friendly towards patients at the reception desk and over the telephone. The 46 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff, several describing them as ‘top class’.

Patients said staff were compassionate and understanding, one comment was ‘the staff treated me with upmost respect’. Patients could choose whether they saw a male or female dentist.

The waiting area was close enough to the reception for conversations to be overheard. Staff told us that they therefore did not discuss treatment in this area. Patients could be brought through to a private area if required. 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.

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 and online. Staff could support patients who do not speak English as a first language through a translation service.

Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to support making treatment choices. Two comments received said ‘I was involved in all the decision making’ and ‘I was given options about what treatments’. The dental records clearly showed patients were informed about the treatment choices available and were involved in the decision making. A range of oral health information and leaflets were available for patients and a wide range of this information was accessible to patients in the waiting area.
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 a high level of satisfaction regarding the responsiveness of the practice, including access to a dentist for an urgent assessment. The practice also took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every six to 24 months depending on a dental risk assessment and rating for each patient. Patients could make routine appointments between their recall periods if they had any changes to or concerns about their oral health.

Promoting equality

An access audit had been undertaken by the practice. The dental centre was on the first floor above the medical centre. There was no lift and therefore the premises were not accessible to patients using a wheelchair or with reduced mobility. Any patient with accessibility issues has to travel 70 miles to another dental centre for treatment. A hearing loop was not available. This had been identified as a risk and had been on the risk register since June 2018 and remained unresolved.

Access to the service

The opening hours of the practice were displayed in the premises, recorded on the answer phone message and available in the practice leaflet. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. Emergency clinics were held twice a day. On-call arrangements were in place for access to a dentist outside of working hours and details of this were held at the guardroom should patients require this information when the practice was closed.

Concerns and complaints

The SDO had overall responsibility for complaints. The practice manager had the delegated responsibility for managing the complaints process. A process was in place for managing complaints, including a complaint register. Staff told us that verbal complaints were recorded and responded to. There had been three complaints in the last 12 months. These were regarding excessive waiting times for access one clinician. This issue had since been resolved with the complainants’ being given an explanation and an apology. No other complaints had been made. We saw patients waiting on the day were seen at their appointment time.
Are services well-led?

Our findings

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

Governance arrangements

The acting SDO had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for the day to day running of the service and was qualified to do so. We spoke with staff who told us that they were clear about lines of accountability.

An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance of military primary health care services, including dentistry. The CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by practices to assure the standards of health care delivery within DMS. When a CAF review is undertaken by RHQ it is referred to as a Health Governance Assurance Visit (HGAV). The last HGAV was undertaken in 2016 and a management action plan was in place to address a number of issues.

A report was sent to regional headquarters (RHQ) each month that reported on a range of clinical and non-clinical statistics and activity at the practice. For example, the report included an update on the status of the practice’s performance against the military dental targets, complaints received and significant events.

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.

Peer review meetings were being established with the DO. This would include meeting to discuss cases, particularly complex cases and to discuss the progress of clinical audits. Nurses also had their own meetings. Clinical staff also participated in peer review at the quarterly regional dental meetings.

Leadership, openness and transparency

There was an open and transparent culture in place and patients and staff knew how to address any concerns they might have. Staff took pride in their work and we saw positive interactions between all staff members, regardless of seniority.

The management team at the practice had the capacity and skills to deliver good quality, sustainable care. They were knowledgeable about issues and priorities relating to the quality and future of services.
**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were effective. Radiology audits were undertaken by all clinicians and were in line with IRMER requirements. Infection control and health and safety management demonstrated that audit work in these areas had led to improvement. An audit of appointment waiting times was in its infancy, this was born out of complaints analysis.

The staff team attended a regional training day, where they received training updates and had an opportunity to participate in clinical peer review. Staff received mid and end of year annual appraisal. We saw from the staff monitoring system that staff appraisals were up-to-date. Staff were encouraged to access websites providing dental CPD to further their professional development and clinical skillset.

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

The practice involved patients, the public, staff and external partners to support sustainable services.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.