Culdrose Dental Centre

RNAS Culdrose, Helston, Cornwall

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Are services safe?	**No action required**	✓
Are services effective?	**No action required**	✓
Are services caring?	**No action required**	✓
Are services responsive?	**No action required**	✓
Are services well led?	**No action required**	✓

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Summary

About this inspection

We carried out an announced comprehensive inspection of Culdrose Dental Centre on 14 and 29 September 2021. The first day we gathered our evidence remotely and the lead inspector visited the service on the second day.

As a result of this inspection we found that this practice was safe, effective, caring, responsive and well led in accordance with CQC's inspection framework.

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the Defence Medical Services.

Background to this practice

Located in Cornwall, Culdrose Dental Centre is a three-chair practice providing a routine, preventative and emergency dental service to a military population of 1820 service personnel.

The dental centre is open Monday to Thursday 08:00-16:30 and Fridays from 08:00 to 12:00.

Out-of-hours (OOH) arrangements are in place through a duty dental officer.

At the time of the inspection the staff team comprised:

Senior Dental Officer (SDO)	one
Civilian Dentist	two (job share)
Military dental nurses	one
Civilian dental nurses	four (job share)
Dental hygienist	one (locum)

Our Inspection Team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and a dental nurse/manager.

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 practice manager, the senior dental officer, the civilian dentist, the dental nurses and the hygienist. 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.

We also spoke with five patients who were currently registered at the dental centre. All the feedback from patients was positive.

At this inspection we found:

- 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.
- The clinical staff provided patients' care and treatment in line with current guidelines and all clinicians maintained detailed patient treatment care records. Staff provided preventive care and supported patients to ensure better oral health.
- The clinical staff provided care and treatment in line with current guidelines. Clinical notes were detailed and accurate.
- 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.
- 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.
- Systems for assessing, monitoring and improving the quality of the service were in place.
- Staff received a comprehensive induction when they started work at the dental centre. Training requirements for staff had been met, including ongoing infection control training for the lead nurse.

- There was effective leadership and a culture of continuous improvement. Staff felt involved and supported and worked as a team.

There was one area for improvement:

- Extend and strengthen the audit programme.

Dr John Milne MBE BChD, Senior National Dental Advisor

(on behalf of CQC's Chief Inspector of Primary Medical Services and Integrated Care)

Are Services Safe?

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). There was a comprehensive record of all ASERs, this provided trends analysis and prompted optimal learning. Significant events had been discussed at practice team meetings twice a month and staff we spoke with confirmed what they had learned.

The Senior Dental Officer (SDO) and Practice Manager were 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). These were logged and any required action was recorded as undertaken. As a standard agenda item, they were discussed at practice meetings and minutes maintained.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead for the practice and had completed level two safeguarding training, the dental centre was co-located with the medical centre where the Senior Medical Officer was Level 3 trained. All other members of the staff team had completed level two safeguarding training which was appropriate to their roles. Staff we spoke with were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. Staff told us that they could approach the SDO if they identified and needed to report suspected abuse.

Staff understood their duty of candour and were able to recall an occasion where a patient had been contacted following an error in their patient record.

The dentists were always supported by a dental nurse when assessing and treating patients. Nurses were sometimes able to work as chaperones for the dental hygienist and always when aerosol generating procedures were required. 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 in the staff room and online. We saw the safeguarding policy was up to date and within it there was a QR (quick response) code which could be scanned for the most up-to-date NHS contact details. Staff described what they would do if they wished to report in accordance with DPHC policy.

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 dentists 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. We saw a recent ASER had been raised following the fracture of a rubber dam clamp, we saw how this had been learnt from and that extra safety measures were now in place to prevent it from happening again.

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

The defibrillator and emergency drugs kit were well maintained. 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). The SDO was new in post and established that no interactive simulated emergency scenarios had recently taken place. As a result of this plans were in place for some training including some joint training with the co-located medical centre.

An AED was available in the medical centre which was in the same building. 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.

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 policy.

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.

DPHC had produced a standard operating procedure (SOP) for the resumption of routine dentistry during the COVID-19 pandemic. The Culdrose dental team demonstrated that they were following this guidance closely in order to protect both staff and patients from potential COVID infection. Risk assessments were in place for individual staff members, COVID-19 testing was undertaken regularly by all staff and symptoms to look out for were displayed around the dental centre. The waiting room had been reconfigured to enable social distancing, hand sanitiser was provided throughout the building and the centre had procured a large stock of personal protective equipment for use by both staff and patients. Dental staff knew which aerosol generating procedures presented a low or high risk and, depending on whether high volume suction and/or a rubber dam was used, fallow periods of varying lengths between patients were built into the appointments schedule.

Infection control

An Infection prevention and control (IPC) policy was in place, it included supporting protocols, which took account of the guidance outlined in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health. It was also available electronically. The lead dental nurse was currently on an IPC course due to be completed later this year, the practice manager was IPC lead for the dental centre supported and overseen by the Senior Dental Officer. All practice staff were up to date with IPC training and records confirmed they completed refresher IPC training every six months. IPC audits were undertaken twice a year.

The surgeries, including fixtures and fittings, were tidy, clean and clutter free. Environmental cleaning was carried out by a contracted company twice daily. Clean and dirty areas were clearly labelled and were used correctly by staff.

Decontamination of dental instruments took place in the surgeries, this was a temporary measure, a purpose-built central sterilisation services department (CSSD) had been installed and was due to be finished within the next month. Sterilisation was undertaken in accordance with HTM 01-05. Routine checks were in place to monitor that the ultrasonic baths and autoclaves were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were routinely checked by staff: we

saw that the sterilisation use-by-date was in place and we did not note any out of date items.

The legionella risk assessment for the practice had been undertaken by the station and it was specific to the requirements within a health centre.

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. An equipment service audit was undertaken annually. The next test of portable electrical appliances had been booked for October this year.

Prescription sheets were numbered and stored securely. Antibiotics were held at the practice and monthly checks undertaken by the SDO. Protocols were in place for the safe management of antibiotics and correct labelling techniques were in place. The SDO was new in post and had planned to undertake an audit of antibiotic prescribing. Medicines that required cold storage were kept in a fridge, and cold chain audit requirements were in place and recorded.

Checks of medicines, including controlled drugs, were routinely undertaken by the practice staff with periodic checks by the SDO and the regional dental team.

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(ME)R (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 dentists justified, graded and reported on the X-rays they took. All clinicians carried out annual radiology audits.

Are Services Effective?

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) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. Treatment was planned in accordance with the BPE (basic periodontal examination - assessment of the gums) and caries (tooth decay) risk assessment. The dentists also followed appropriate guidance in relation to recall intervals between oral health reviews.

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. Clinicians were following guidance from the British Periodontal Society around Periodontal staging and grading.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure better oral health. Dental nurses delivered oral health education including smoking cessation and alcohol intake management. Dental records showed that lifestyle habits of patients, such as smoking and drinking, were included in the dental assessment process. 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 to some patients. Referrals could be made to other health professionals, such as referrals to the medical centre for advice about smoking, diet and alcohol use.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

The dental team participated in the health and wellbeing promotion fairs held at the base, but these were currently restricted due to COVID-19.

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.

Staffing

Staff new to the practice had a period of induction that included a generic programme and induction tailored to the dental centre. 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 that all staff had undertaken training they were required to complete.

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

The dental team confirmed that the staffing establishment and skills mix were appropriate to meet the dental needs of the patient population and to maximise oral health opportunities. The dental team were working hard to deliver the best level of care possible whilst abiding by the current COVID-19 restrictions.

Working with other services

Staff worked together and with other health and social care professionals to deliver effective care and treatment. Staff confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. Referrals were sent via an electronic referral service, logged on a register and regularly checked.. We discussed this process and we agreed this could be further strengthened by regular audit to ensure all referrals were dealt with in a timely manner.

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 received clear information about their treatment and that treatment options were discussed with them.

Staff had a good awareness of the Mental Capacity Act (2005) and how it applied in their setting and daily work.

Are Services Caring?

Respect, dignity, compassion and empathy

Staff were aware of their responsibility to respect people's diversity and human rights. We spoke with five patients and they all confirmed that the standard of dental care they received was good. Discussions suggested that staff listened to them and explained what they were going to do, staff ensured that discomfort was kept minimal and staff were kind and respectful.

For patients that were particularly anxious, the practice offered the opportunity to make a longer appointment and talk through their anxiety if appropriate. We saw a compliment received from a very anxious patient thanking the staff for their understanding and for taking extra time with them. If necessary other strategies for reducing anxiety could be considered, such as referral to the mental health team, medication pre-treatment or as a final option referral to an enhanced practice for conscious sedation. Alerts were placed on the patient's electronic record to identify if they were anxious.

The waiting area was close enough to the reception for conversations not to be overheard. The reception computer screens were not visible to patients and staff said that they 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 did 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. 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 posters were available for patients in the waiting area.

Are Services Responsive?

Responding to and meeting patients' needs

Patients could make routine appointments between their recall periods if they had any changes to or concerns about their oral health. Routine appointments could be accommodated within five working days. Emergency appointments slots were available each day.

The practice also took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every 6 - 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

A DDA (detailed disability access) audit had been completed. The dental centre was open and spacious and could accommodate wheelchair users, with wide doors and an accessible toilet. Parking bays were available for patients with a disability. A hearing loop was not available as this had not been identified as a need for the population at the station. Patient requests to see a dentist of a specific gender could be accommodated.

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. 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 senior dental officer 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 complaints register. Staff told us that verbal complaints were recorded and responded to. No complaints had been received in the last twelve months.

Are Services Well Led?

Governance arrangements

The senior dental officer (SDO) had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for a large portion of the day to day running of the service. Staff we interviewed were clear about current lines of accountability and knew who they should approach is they had an issue that needed resolving. The SDO was new in post and had plans in place to drive improvement within the dental practice, for example conducting more detailed audits and embracing further integration with the medical centre.

A framework of organisation-wide policies, procedures and protocols was 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 referred to them throughout the inspection. Effective risk management processes were in place and followed by staff and checks and audits were in place to monitor the quality of service provision.

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.

All staff felt well supported and valued. Staff told us that there were clear lines of communication within the practice. Team meetings were held twice monthly.

Peer review meetings were also established. Dentists met to discuss cases, particularly complex cases and to discuss the progress of clinical audits.

Information governance arrangements were in place 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 dental care records were stored securely.

Leadership, openness and transparency

Staff reported that they were happy working at Culdrose Dental Centre and that they were able to deliver a good standard of care to patients. All staff were confident that there was an open and transparent culture in place and that they knew how to address any concerns they might have.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective. The dental centre had implemented guidance set out by DPHC around the safe return to dental care provision during the COVID-19 pandemic.

The staff team had opportunities 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 (continuing professional development) to further their professional development and clinical skillset.

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

Due to COVID-19 restrictions, the suggestion box previously located in the waiting area had been removed. However, emails were sent to patients asking for their feedback, any feedback received was then discussed at the practice meeting.

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