

## Drake Dental Centre

HMNB Devonport, Plymouth, Devon, PL2 2BG

### 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?	<b>No action required</b>	✓
Are services effective?	<b>No action required</b>	✓
Are services caring?	<b>No action required</b>	✓
Are services responsive?	<b>No action required</b>	✓
Are services well led?	<b>No action required</b>	✓

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# Summary

## About this inspection

We carried out an announced comprehensive inspection of Drake Dental Centre on 4 June 2024.

**As a result of the inspection we found the practice was safe, effective, caring, responsive and well-led in accordance with the Care Quality Commission's (CQC) inspection framework.**

CQC does not have the same statutory powers with regard to improvement action for Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare 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 Defence delivered healthcare. DMSR is committed to improving patient and staff safety and will take appropriate action against CQC's observations and recommendations.

This inspection is one of a programme of inspections CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

## Background to the practice

Located within the Naval Base in Devonport, HMS Drake Dental Centre was providing a service to a patient population of approx 4,156 at the time of this inspection. The dental centre has 9 surgeries; 7 on the first floor and 2 on the ground floor to accommodate patients with mobility needs.

The full range of primary dental care is provided, 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 service. In addition, the practice provides a portable dental unit that can be flown to ships along with a staff team to treat deployed personnel.

Opening times are from 08:00 – 16:00 hours Monday to Thursday and 08:00 to 15:00 hours on Friday (closed for lunch 12:00 to 13:00 hours).

## The staff team

Dentists	Senior Dental Officer (SDO) Deputy SDO (post vacant until 29 July 2024) Enhanced practitioner (part time) Amphibious Dental Officer Foundation dentist Four civilian dentists (full time job share) Two visiting military Dental Officers (1 x weekly clinical session held to support Drake Dental Centre)
Hygienist	Military hygienist Locum hygienist
Dental nurses	Three military nurses Five civilian nurses (1 part time) Three locum nurses
Practice management	Military practice manager Military deputy practice manager Military fleet practice manager Britannia Royal Naval College (BRNC) practice manager
Administration	Two civilian dental receptionists

## Our Inspection Team

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

## 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 Senior Dental Officer, practice manager and a wide variety of staff. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We checked the building, equipment and facilities. In addition, we reviewed patient feedback and interviewed patients who were registered at the dental centre.

**At this inspection we found:**

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Leadership at the practice was inclusive and the team worked well together.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Systems were in place to support the governance and risk management of the practice.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Staff were up-to-date with appraisals, required training and continuing professional development.
- Clinicians provided care and treatment in line with current guidelines.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Processes for assessing, monitoring and improving the quality of the service were in place.
- Arrangements were in place to support the safe use of X-ray equipment.

**The Chief Inspector recommends to the practice:**

- Staff should have prompt access to Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) should they need to reference it.
- Staff should be aware of the sound of the emergency alarm so it is responded to in a timely way when activated.

**Mr Robert Middlefell BDS**

**CQC's National Professional Advisor for Dentistry and Oral Health**

## Our Findings

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### Are Services Safe?

#### Reporting, learning and improvement from incidents

Incidents which impacted the delivery to patient care were reported through the Automated Significant Event Reporting (ASER) DMS-wide system and were recorded on the ASER register. Although all staff had a log-in to the system, some told us they were unsure of how to use the ASER system as they had not needed to report a significant event. In situations like this, the Senior Dental Officer (SDO) or practice manager supported staff with reporting an incident to ensure they used ASER correctly. The ASER log-in for a locum was not working and this was being addressed at the time of the inspection.

The ASER register showed 4 significant events had been raised in the last 12 months. Accidents and near misses were being reported via the Defence Unified Reporting and Lessons System (DURALS).

Staff had a good understanding of the types of incidents that met the criteria for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (referred to as RIDDOR). Such incidents were reported through the ASER system.

Incidents and significant events were discussed during practice meetings and at the daily morning huddle so all staff are aware at the earliest opportunity. Any incident or significant event that had occurred was also emailed to staff for awareness particularly if any staff was absent from the morning huddle or practice meeting.

A Central Alerting System (CAS) register was in place that included a link to the alert and confirmation as to whether the practice held the product the alert concerned. Alerts were printed and staff were required to sign to indicate they had read the alert. Minutes of the practice meetings showed CAS alerts were discussed as a team.

#### Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead and the practice manager was the deputy lead. The majority of staff were up-to-date with safeguarding training at a level appropriate to their role. There were mitigating circumstances for staff who were out-of-date and plans were in place to address this. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. Patients who were vulnerable were identified through the dental centre's Standing Orders.

Organisational safeguarding information was available in hard copy in the waiting room. The safeguarding toolkit was available on SharePoint and staff were encouraged to download the app.

Clinicians were aware of the duty of candour principles; a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The duty of candour principles were displayed. A duty of candour register was maintained and

it was linked to the ASER register. Duty of candour mandated training was monitored by the deputy practice manager.

The SDO was always supported by a dental nurse when treating patients. When fully staffed, the practice could accommodate a nurse supporting the hygienists.

The chaperone policy was displayed in the waiting room and was accessible for patients to view. It was available in the staff room for staff to access and available electronically on SharePoint.

The practice had a good relationship with the medical centre team whom they could call on for additional support if needed. Although staff rarely worked in the building alone, a lone working risk assessment was in place and was reviewed in March 2024. The lone worker policy was available on SharePoint.

There were safety alarms available in the surgeries to support staff working alone. We tested an alarm on the day and it took over 1 minute for a member of staff to respond.

A dental dam was used routinely for composite restorations as well as endodontics (root canal treatment). Our review of 6 patient records showed a dental dam was used or considered for all restorations and endodontics.

The business continuity plan was available on SharePoint and was last reviewed in May 2024. The plan had recently been actioned during a low level IT outage.

### Medical emergencies

The SDO was the lead for medical emergencies and the practice manager was the deputy lead. There were 2 emergency resuscitation kits. The kit on the ground floor was a new purpose-designed bag now widely used across Defence Primary Healthcare (DPHC) Dental (D). The kit on the first floor was a metal trolley used widely across DPHC medical facilities. Although easily available and visible during working hours, both were tamper tagged and stored in a locked surgery when the practice was closed. Emergency medicines were protected by tamper tags. Temperatures were monitored and recorded.

In-service medical emergency training was facilitated for the staff quarterly, often in conjunction with the medical centre staff team. An external military first aid instructor visited the practice twice a year to assess the resuscitation skills of the staff and their proficiency with using the automated external defibrillator (AED). Records showed the majority of staff were up-to-date with training in managing medical emergencies including annual basic life support, the use of the AED and anaphylaxis. There were mitigating circumstances for staff who were out-of-date and plans were in place to address this. Staff confirmed that scenario-based medical emergency training was routinely facilitated. We checked the kits and emergency medicines. Where we considered minor improvements could be made, we discussed these with the SDO during the inspection. For example, acquiring a pocket mask with an oxygen port and shorter length needles.

Two dental nurses were trained in level 2 first aid and were the department's nominated first aiders. Four first aid boxes were available. The biohazard spill, eye care and mercury spillage kits were checked regularly to ensure they were in-date.

We discussed with the SDO how patients were made aware of what to do if they experienced pain or their condition deteriorated. Post operative instructions were explained to the patient, particularly following extractions and endodontics. Patients experiencing severe pain were seen at the practice on the same working day.

Although records showed all staff had received training in sepsis/recognising the deteriorating patient, some staff we spoke with were unable to recall completing the training. We were advised the SDO planned to deliver a sepsis training session to the team in August 2024. Sepsis posters were displayed in the reception area and the dental surgeries. Administrative staff told us they would refer the patient to a clinician if they were concerned a patient was displaying symptoms of sepsis.

### Staff recruitment

The practice manager had oversight of the recruitment of permanent and locum staff. The full range of recruitment records for permanent staff was held centrally. Evidence was in place to confirm that recruitment checks had been completed for staff new to the practice. These included a Disclosure and Barring Service check to ensure staff were suitable to work with vulnerable adults and young people. The registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role were also monitored. Copies of induction paperwork and all certificates were retained by the practice manager.

### Monitoring health & safety and responding to risks

The health and safety lead for the base carried out an annual safety, health, environment and fire (referred to as SHEF) in November 2023 and minutes showed the outcome of the SHEF inspection was discussed at a practice meeting.

A risk register specific to the practice was held on the DPHC (D) risk register with risks managed in accordance with the '4 Ts' (transfer, tolerate, treat, terminate). A range of regularly reviewed risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The 5-yearly fire risk assessment was undertaken in July 2020 and it identified the building as a green or tolerable risk. The fire alarm was checked weekly and firefighting equipment and evacuation measures were checked each month. Staff advised us that they had participated in an annual fire evacuation drill. A plan of the building was displayed indicating the fire exits and muster point.

The dental centre was located in a building that was erected in the 1970s and, at that time, had an expected life-span of 5 years. This building was intended to be a temporary arrangement. Although visually the building appeared sturdy, the thin concrete walls could not support the weight of wall-mounted radiographic equipment. Instead, pedestal-mounted equipment was used. In addition, areas of the building were experiencing 'concrete cancer' and water ingress. This was visible in one ground floor room that was no longer in use. There was asbestos in the building but not in clinical areas.

A short term plan was in place to relocate the dental centre in 2025 to a modular building. The long term plan was to build a 'cottage hospital' within 5 years to include all DPHC



units within HMS Drake. Despite plans to move to a new building, minor work service requests were responded to promptly and appropriate repairs completed to the team's satisfaction.

The fleet practice manager was the lead for Control of Substances Hazardous to Health (COSHH) and the overall dental centre practice manager was the deputy lead. COSHH products were stored securely and risk assessments were reviewed annually. Following the inspection, the practice confirmed risk assessments would be reviewed on receipt of new product and when safety data sheets were updated. Staff had access to both paper copies and electronic versions of the COSHH risk assessments, and to electronic versions via a SharePoint link. A COSHH inventory was displayed indicating the expiry date of each product. The contracted cleaner kept cleaning products in a locked cupboard and had access to the company's COSHH risk assessments.

For the purposes of the inspection, the contractor provided the practice with the legionella risk assessment for the building and the monthly temperature checks of the sentinel water outlets (first and last taps on the water distribution system). The legionella risk assessment was carried out in May 2021 and had been reviewed each year since.

Dipslide testing used to check for bacteria in water was completed monthly. The tests were secured in a cool dark area for 72 hours prior to review. Quarterly dipslide tests were sent to an external organisation for assessment. The last quarterly assessment report was received in April 2024. If required, a stand-alone purge of the water lines was undertaken. Water lines were flushed for 2 minutes at the start of each session and for 10 to 20 seconds between patients.

Used instruments were transported in covered clip-locked hard plastic boxes. A log was in place to ensure containers were collected by a contractor from the locked external store. An incident had occurred when a container was punctured. This was raised through the ASER system as an incident and was discussed with the team for wider awareness.

The practice adhered to relevant safety laws when using needles and other sharp dental items. A sharps policy was available and sharps boxes in clinical areas were labelled, dated and used appropriately. Sharps containers were closed when the indicated levels were reached. The training log confirmed staff had received in-service training on how to manage sharps injuries. Training in snapping ampoules/drawing up syringes was provided for staff in November 2023. If a sharps injury occurred, both staff and patients were referred to a doctor at Drake Medical Centre. The last sharps injury was in June 2023 and was reported via the DURALS process. It was also reported through the ASER system. The ASER report and management of the incident resulted in a change to organisational policy.

The same model dental local anaesthetic syringe and compatible needle sharps box routinely used across DPHC(D) was in use at the practice. All new staff received sharps training at induction, which was refreshed every 6 months. Single use matrix bands were used, which did not require disassembly for processing through the decontamination process. The practice also used single use scalpels.

### Infection control

One of the dental nurses was the lead for infection prevention and control (IPC) and had completed the IPC lead course through the Dental Nurse Network. The majority of staff were up-to-date with IPC training. There were mitigating circumstances for staff who were out-of-date and plans were in place to address this.

Measures were established to minimise the spread of infectious diseases. Hand washing guidance was displayed, hand sanitiser was available throughout the building and staff had access to a sufficient stock of personal protective equipment. An IPC policy supported by 6 monthly training for all staff was in place. IPC training was recently facilitated following an internal audit of dental instruments. Staff were encouraged to wipe used instruments and soak them as soon as possible to reduce the chance of used materials or blood binding to the stainless steel.

A 'no-clinical PPE' policy was in place, so staff did not move from one area to another whilst wearing contaminated gloves. Staff had received the appropriate vaccinations. Clear guidance was in place for staff to take should they begin to feel the symptoms of an upper respiratory tract infection.

The practice SharePoint page included a link to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). However, not all staff we spoke with were aware of the document or where to locate it. IPC audits were undertaken over a 12 month period with 2 sections completed 6 monthly. The last full audit was completed in February 2024.

The practice had an appropriate central sterile services department (CSSD) with clearly identifiable clean and dirty areas. Staff had a full understanding of the complete process and provided a full demonstration and talk through of the decontamination process.

Environmental cleaning was carried out by a contractor and a schedule was in place describing the cleaning arrangements for each area and frequency. The cleaning contract included a deep clean of carpeted areas. Cleaning products and equipment were stored securely. Cleaning was undertaken in the morning and afternoon. The surgeries were cleaned by the nurses each day and deep cleaned once a week. The practice manager monitored the cleaning log signed by the cleaner.

One of the dental nurses was the lead for clinical waste. Clinical waste was transferred from the department daily into locked external clinical waste bins. Extracted teeth without fillings were disposed of in the sharps bin and those with amalgam were disposed of in an amalgam waste container. Gypsum (for taking dental impressions) waste was stored in gypsum pots and held in the laboratory until collection. Waste was recorded in a clinical waste log. It was collected every Tuesday and a consignment note issued to the department from the waste collector. The consignment notes were uploaded to SharePoint.

The practice used an amalgam separator and staff received training in its use at induction and during the 6-monthly IPC training. Used and out-of-date amalgam capsules were placed in an amalgam safe.

### Equipment and medicines

The practice manager was the lead for equipment care and the deputy practice manager was the deputy lead. Daily checks were undertaken and recorded for all equipment in the surgeries, laboratory and CSSD. Clinical equipment was serviced annually by the medical and dental servicing section (a military capability referred to as MDSS). All equipment was in-date for servicing and testing. A fault log for equipment was held on SharePoint and also included equipment loaned to other Defence dental centres. Portable appliance testing (PAT) was undertaken. We noted that one appliance had not had a PAT test and highlighted this at the time of inspection.

The surgeries were clean and tidy. Equipment was latex free except for one item as there were no latex free alternative available at the time of the inspection.

A dental nurse was assigned to the stock room to ensure all stock was managed and kept in-date. A monthly stock check was completed for all surgeries. The pharmaceutical fridge temperature was checked twice a day and a record was maintained of the checks. The stock room temperature was controlled with air conditioning and the temperature was recorded daily.

Serialised prescription sheets were held securely at reception. A process was in place for the prescribing dentist to obtain a prescription form, load it onto the printer and return to the surgery to send the prescription to the printer. Guidance was in place regarding this process to minimise wasting serialised sheets and confusing records. The patient's DMICP number was recorded on the prescription log against the serial number. The pharmacy technician based in the medical centre dispensary advised that the number of dental prescriptions was low and were completed correctly therefore no targeted audits had been undertaken recently. Over-labelled high fluoride prescription-only toothpaste was locked in a metal drugs cabinet. We discussed with the SDO the potential for fluoride toothpaste to be available on repeat prescription. Out-of-date medicines were disposed of via the pharmacy. Where appropriate, destruction certificates were provided by the pharmacy.

An in-service first cycle antibiotic prescribing audit based on nationally recognised standards was undertaken between November 2023 and April 2024. Five patients were prescribed antibiotics by 10 clinicians over a 5½ month period. Prescribing was limited to 2 types of antibiotics. Peer review of results had taken place. The next audit period was due to start at the beginning of July 2024.

### Radiography (X-rays)

Suitable arrangements were in place 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 for the practice was identified. The SDO was identified as the Radiation Protection Supervisor (RPS). Signed and dated Local Rules were displayed in each surgery along with safety procedures for radiography. A rectangular collimator was available on all intra oral units. Staff were aware the new design had a tendency for the lead lining to peel slightly and create a white mark on the image; this rarely impacted diagnostic quality.

Although not routinely needed, dosimeters (used to measure exposure to ionising radiation) were available for clinical staff. They were changed monthly and retained by the individual clinician even if they moved between surgeries. Dosimeters were sent to the Defence Science and Technology Laboratories for analysis and results were reviewed by the RPS each month.

X-ray equipment was maintained in line with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). Staff requiring IR(ME)R training had received relevant updates.

Daily test images were taken each morning and each image was reported electronically. Summaries of the images were printed off each week and the digital ones deleted. Although laborious, this process was in accordance with DPHC (D) policy. The clinical records we reviewed showed X-rays were quality assured. The dentists justified, graded and reported in the patient's record the outcome of the X-rays they took. A quality assurance radiology audit was completed every 6 months. Cycle 1 was undertaken between 15 January 2024 and 9 February 2024. The audit resulted in 97% of the images graded as '1' which was well above national guidelines.

## Are Services Effective?

### Monitoring and improving outcomes for patients

Our review of patient records demonstrated the treatment needs of patients was assessed in line with recognised national guidance. The small sample of patient records we reviewed showed the National Institute for Health and Care Excellence, Scottish Intercollegiate Guidelines Network, the Scottish Dental Clinical Effectiveness Programme and the British Society of Periodontology (BSP) were often referenced. BSP guidance was followed for treatment plans. However, limited dental hygienist capacity and a shortage of nurses trained in oral health meant it was a challenge to adhere to and complete the treatment plans.

The records we reviewed included 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. A medical and dental history assessment was completed at the patient's initial consultation and was checked for any changes at each subsequent appointment.

All clinicians understood the underlying occupational health requirements of patients including prioritisation for assessment based on Periodic Dental Inspections (referred to as PDI) and treatment. A basic periodontal examination, assessment of the gums and caries (tooth decay), was carried out at each periodic inspection. The practice had dedicated military dental nurses for specific units or groups and they addressed prioritisation in accordance with the Chain of Command's direction. The military dental fitness targets were closely monitored by the Senior Dental Officer (SDO).

### Health promotion and prevention

Two dental nurses were the lead and deputy lead for oral health education. The patient records we reviewed showed proposed treatment pathways and information given to patients was in accordance with the Delivering Better Oral Health toolkit.

The alcohol screening tool (referred to as AUDIT-C) was used to capture data captured when patients registered and at further appointments with the dentist and hygienist. Advice and signage was provided in line with AUDIT-C guidelines and written advice cards issued. The opportunity to signpost to other healthcare providers in the medical centre was at the upper threshold.

Clinical records demonstrated that each patient was routinely asked about their oral hygiene routine, dietary habits and smoking, including smokeless tobacco and vaping. Dietary, oral hygiene and lifestyle habits were captured on the arrival form and followed up with a brief intervention. Checks were made at subsequent appointments. It was unclear if the benefits of nicotine replacement therapies were fully explored with each smoker. There was limited evidence of routine referral to the medical centre, rather informing patients that a service was available. The medical centre had at least 2 smoking-cessation trained nurses.

To minimise caries or tooth decay, 'spit don't rinse' was promoted along with options, such as daily mouth rinsing, fluoride varnish treatment twice a year and prescription only

toothpaste. For periodontal disease, the dentists routinely used brief interventions. However, follow up was a challenge given limited dental hygienist capacity. At the time of the inspection, dentists were undertaking the majority of hygiene work. We highlighted that an option to consider was engaging the skill set of oral health trained dental nurses. A periodontal care audit was due to start at the week after the inspection.

A variety of dental health promotion information was available in the waiting area. At the time of the inspection information included a display in relation gum disease, smoking cessation and women's health and dental care. Information leaflets about a variety of topics were available for patients to take away. The practice participated in health fairs facilitated by the base with the last fair held in 2023.

### Staffing

The practice supported a diverse and geographical dispersed patient population. Dedicated deputy practice managers were identified for Drake, Fleet and Amphibious/Dartmouth Royal Naval College. Patients from Abbey Wood and Bristol were also treated at the practice. In addition, the SDO and practice manager managed 3 outlying dental centres, so staffing levels took these additional duties into account. The designated dentist complement at the time of the inspection was appropriate for the size and dental need of the patient population.

The capacity of the dental hygienists was limited as the locum hygienist worked 1 day a week and the military hygienist was absent from the service with no return to work date identified. However, staff we spoke with confirmed there was sufficient capacity within the team to meet the dental and occupational needs of patients. Although recruitment was ongoing, there continued to be a reliance on locum staff.

Coordinated by the practice manager, a full Defence Primary Healthcare (DPHC) induction programme was in place for all new and locum staff. Each member of staff had an induction folder and a checklist was completed to ensure all areas are covered.

Staff training was overseen by the practice manager and one of the dental nurses was responsible for monitoring in service training for the team. Training was recorded on the DPHC Dental (D) Personnel Management System (PMS) and also on the in-service training log. Links for training were available on the PMS.

Staff were responsible for their own continuing professional development (CPD) records, required for maintaining registration with the General Dental Council. DPHC (D) was in the process of providing membership to an online CPD website to support staff with access to CPD training. CPD opportunities were shared between staff at practice meetings or via email. Staff were given opportunities to attend dental care professional conferences and regional study days.

### Working with other services

Referrals for oral surgery were mainly made to the maxillofacial oral surgery department at Derriford Hospital in Plymouth. There was approximately a 12-month wait for routine surgical extractions, such as third molars/wisdom teeth. A fast-track arrangement had been developed for high occupational priority and patients with a high clinical priority.

Lympstone Dental Centre took some referrals and the SDO and deputy SDO dealt with more routine surgical extractions. In the absence of a dental motor for oral surgery, they often referred the patient as a hospital environment was deemed more appropriate.

Both the practice manager and deputy practice manager had oversight of referrals. A referral log was maintained and reviewed weekly by the deputy practice manager. Receptionist staff also had access to the log to respond to any patient query about their referral.

Dental laboratory work was primarily undertaken via dental intra-oral scanning and sent electronically; it rarely required a separate laboratory form (FMed285). Some alginate impressions and models were cast at the practice in the dedicated laboratory, primarily for the foundation dentist to practice. Turn-around time was approximately 3 weeks.

### **Consent to care and treatment**

Feedback from patients confirmed patients were given information about treatment options and the risks and benefits of these so they could make informed decisions. The patient records we looked showed verbal or written consent was obtained depending on the treatment undertaken. The SDO had a good awareness of the Mental Capacity Act (2005) and provided an example of how it could apply to their patient population.



## Are Services Caring?

### Respect, dignity, compassion and empathy

We received feedback from 41 patients via inspection feedback cards and direct interviews with patients who had appointments on the day of the inspection. All patients who provided feedback said staff treated them with kindness, respect and compassion.

Patients told us they were given adequate time for their appointments so they did not feel rushed. Although rarely experienced, extra time was accommodated for patients with a dental anxiety. A local dental access centre was recently used to provide intravenous sedation to facilitate treatment for a patient.

Staff had access to the 'Big Word' translation service. Posters were displayed in the waiting room and reception highlighting the availability of this service. When foreign ships were docked, a translator on board attended the dental appointment with the patient to facilitate translation.

The practice provided care to a local unit, which draws service personnel from across the country. This unit provided specialised rehabilitation support and/or preparation for military discharge and transition to civilian life. Some of these patients have presented with wider social, welfare or health needs.

### Involvement in decisions about care and treatment

Feedback from patients suggested clinicians provided clear information to support patients with making informed decisions about treatment choices. This included verbal explanations and printed information. Clinicians talked through treatment options with patients and checked for their understanding. The dental records we looked at confirmed patients were involved in decision making about the treatment choices available.

Resources employed to involve patients included the use of a templated, but targeted consent form, which asked key questions regarding the activity proposed. In addition, the practice used a wide variety of visual aids to support patients with maximising informed consent. For example, small X-rays could be viewed sequentially at medium size or expanded to fit a full display screen on the clinicians' desk and manipulated to identify features. The intra-oral scanning software permitted a visual representation of a patient's teeth or tooth so they can better understand recommendations and proposed treatment.



## Are Services Responsive?

### Responding to and meeting patients' needs

Clinicians followed National Institute for Health and Care Excellence guidelines in relation to recall intervals between oral health reviews; between 3 and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. We reviewed the clinical records for 6 patients. Five of the 6 were set to a 12 month recall period, including 2 patients with a 14-year history of periodontal disease, who did not have periodontal recalls recorded on any occasion previously. One of the 3 patients who had been assessed as low in all 4 parameters was placed appropriately on an 18 month recall timeframe; the other 2 patients had a recall period of 12 months. Patients could make appointments between recall intervals. Receptionist staff were empowered to triage the allocation of appointments.

### Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in February 2024. Actions identified had been met. Accessible parking and wheelchair access were available. There were 2 surgeries and an accessible toilet on the ground floor to accommodate patients with mobility needs. At the time of the inspection, a hearing loop was not required based on the needs of people who used the building. The staff team had completed training in equality and diversity.

### Access to the service

At the time of the inspection, the next available routine appointment with a dentist could be accommodated within 2 to 3 weeks. Patients requiring an emergency appointment during working hours could be seen on the same day. In response to a pain presentation audit, 2 pain slots were available at 15:00 hours. All emergency patients were triaged and seen sooner if deemed necessary. Patients could see an enhanced practitioner within 2 to 3 weeks for a routine appointment and within a week for an urgent appointment. At the time of the inspection, there was limited appointments available with a hygienist.

Out-of-hours (OOH), patients had access to the duty dentist within the region. Patients were triaged and seen as necessary. The practice information leaflet detailed dental access out-of-hours arrangements.

Information about the service, including opening hours and access to an emergency OOH service was displayed on the front door of the practice and in the practice information leaflet.

### Concerns and complaints

The Senior Dental Officer was the lead for complaints and the practice manager was the deputy lead. Complaints were managed in accordance with the Defence Primary Healthcare complaints policy. Staff had received training in managing complaints. A process was in place for managing complaints, including a complaints register for written and verbal complaints. Complaints were a standing agenda item at the practice meetings.

## **Are Services Responsive? | Drake Dental Centre**

The practice had received 4 written complaints since January 2022 with the most recent in May 2023. All complaints had been resolved to the satisfaction of the complainants.

Patients were made aware of the complaints process through the practice information leaflet and information in the waiting area. A complaints, compliments and suggestions box was located in the waiting area along with forms to complete. Feedback from patients indicated they knew how to make a complaint.

## Are Services Well Led?

### Governance arrangements

The Senior Dental Officer (SDO) was the lead and the practice manager the deputy lead for healthcare governance. These roles were captured in their terms of reference (ToR). Individual staff also had lead roles in specific areas. The practice manager was reviewing the ToRs to ensure they accurately represented the roles and responsibilities of the current staff team, including the additional 4 dental practices the SDO and practice manager were responsible for.

Short morning team briefs were held to ensure consistent team communication. A 4-weekly rolling programme of practice meetings, training, clinical staff meetings and peer review was established.

The practice manager regularly reviewed governance and risk management systems to ensure they were up-to-date. A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were local dental specific protocols and standard operating procedures that took account of current legislation and national guidance. We noted that not all staff were not familiar with or could easily access the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). The General Dental Council standards were displayed in the practice.

Internal and regional processes were established to monitor service performance. Key performance indicators and dental targets were reviewed by Regional Headquarters (RHQ) and the Chain of Command. The practice used the Health Assessment Framework (referred to as HAF); internal quality assurance system used to monitor safety and performance. Although we were unable to access the report, we were advised that the last internal assurance review was completed in 2022 and that there were no outstanding actions.

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 a login password to access the electronic systems and were not permitted to share their passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. A reporting system was in place should a confidentiality breach occur. Staff had completed the mandated Defence information management training, data protection training and training in the Caldicott principles to protect confidential patient information.

Staff were encouraged with environmental awareness and to use the recycling bins. Staff only printed essential documents and ensured double-sided printing was used.

### Leadership, openness and transparency

Staff said they enjoyed working at the practice and that the leadership team was visible, approachable and supportive. They told us the team worked well together with the collective aim to provide patients with a good standard of care. We heard there was an open and transparent culture and were confident any concerns they raised would be addressed without judgement. Staff were familiar with whistleblowing arrangements.

Whistleblowing information was displayed on the notice board. A dedicated monthly 'white space' session was scheduled to allow for team building opportunities.

The practice manager was due to take extended leave in September 2024. Many of the team expressed a worry about succession planning for the practice manager whilst they were on leave. We discussed this with the leadership team at the time of the inspection subsequently confirmed they raised the issue to the RHQ.

### Learning and improvement

The SDO was the lead for clinical audit/quality improvement. An audit schedule and register was in place. All the required audits had been completed in 2024, including infection prevention and control (IPC), controlled drugs, equality access, clinical waste and radiography. Best practice audits had also been undertaken, including an antimicrobial prescribing audit, consultation records audit and instrument cleaning and decontamination standards. A formally funded project was ongoing with digital intra-oral scanning as it has proven benefits, such as time saving and reduction of retakes for impressions. This was due to be expanded across more of Defence Primary Healthcare Dental.

There was evidence that audit led to improvements. For example, an IPC audit specifically looking at dirty instruments resulted in a reduction in the number of visually contaminated instruments within sealed trays at the second round. Amalgam carriers were specifically identified as difficult to keep clean so additional ones were prepared.

A culture of education and development was embedded with peer review, case discussion, audit and research having a clear benefit to patients. The wide-range of experienced and post-graduate qualified dentists provided support to the foundation dentist, the other junior dentist, the dental hygienists and dental nurses. Clinicians (dentists and hygienists) held a peer review each month to discuss any clinical issues. The enhanced practitioners were involved in the Defence Centre for Rehabilitative Dentistry audit programme and led on webinar sessions.

Mid and end of year staff appraisals were up-to-date.

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

To monitor how well the practice was performing, patients were encouraged to complete the Patient Experience Tool (referred to as the PET survey). To access the survey a quick response or QR code was visible in the dental surgery and printed copies were also available. Staff were encouraged to ensure 2 surveys were completed per clinician each day. A suggestion box in the waiting area was another method that patients could submit feedback. Patient feedback was shared with the team via email and during practice meetings. The practice acted on feedback, such as the installation of a television in the patient waiting room.

The patient feedback survey for a year period 2023/24 generated 170 returns. It demonstrated that 98% of patients were satisfied with their care and 96% said they would feel listened to if they raised a concern.

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Staff were encouraged to give feedback about the service verbally during the morning meeting, practice meeting and via the quality improvement project form. There was also a staff suggestions box where staff can provide feedback anonymously.