Somerset Partnership NHS Foundation Trust

Bridgwater Dental Access Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 September 2015 as part of our planned inspection of community dental practice locations in Somerset Partnership NHS Foundation Trust (SOMPAR). The inspection took place over one day by a CQC dental specialist adviser and the CQC lead inspector. We asked the centre the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found this centre was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found this centre was providing effective care in accordance with the relevant regulations.

Are services caring?

We found this centre was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found this centre was not providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found this centre was not providing well-led care in accordance with the relevant regulations.

Background

Bridgwater dental access centre provides a dental service for all age groups who require a specialised approach to their dental care and who are unable to receive this in a general dental practice.

The service provides oral health care and dental treatment for children and adults who have an impairment, disability and/or complex medical condition. People who come in to this category are those with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability, including those who are housebound or live in a nursing or residential home.

The centre has three treatment rooms, there were two dedicated decontamination rooms (one room for cleaning instruments and the other room for sterilising them) and a dedicated orthopantomogram X-ray

Summary of findings

(provides a view of all teeth and supporting structures) room including digital X-rays within all treatment rooms. The practice is purpose built all treatment rooms are on the ground floor, which are fully accessible for patients with poor mobility. The premises also include an accessible toilet and a waiting area. Patients are greeted by reception staff at the entrance of the centre.

The staff structure covering the Somerset dental access centres comprises of dentists with a specialist interest in oral surgery, general dentists, dental nurses, dental hygienists and dental therapists. There was also a reception administration team comprising of two receptionists per shift.

The centre is open from 8:30am until 12:30pm and 1:30pm until 5.00pm Monday to Friday. Appointments are generally by referral only, although in exceptional circumstances patients can be seen regularly for general dentistry, so there are a small proportion of appointments available for urgent and routine dentistry treatment that would normally be received in a general dental practice.

Additional services provided are an inhalation sedation service where treatment under a local anaesthetic alone is not feasible and conscious sedation is required, domiciliary dental services where dental staff will visit patients in their own home or from within a nursing and residential environment and minor oral surgery is performed here. Somerset Dental Advice Line is based within the premises and provides advice to people within the Somerset area of where they can access dental treatment.

Bridgwater dental access centre has two satellite services based in Burnham on Sea and Minehead. At the Burnham-on-Sea branch they normally open on a Friday for special care dentistry and domiciliary dental services. The Oral Health Team are based at Burnham-on-Sea. At the Minehead branch they normally open two days a week providing special care dentistry and inhalation sedation. The services at Burnham-on-Sea and Minehead have both been temporarily suspended due to staff vacancies. Somerset Partnership Trust are recruiting for both dentist and dental therapist vacancies and once recruitment is complete they will be re-opening again. Bridgwater and Taunton Dental access centres are providing cover for appointments and domiciliary services.

This is the first inspection Bridgwater Dental Access Centre has received since registration in 2011.

We spoke with three patients during the inspection who provided feedback about the service and we received 10 Care Quality Commission comment cards from patients. Patients told us dental staff were kind, compassionate and understanding of their needs. Patients were given time to understand their treatment options and what to expect when visiting for treatments. Patients had confidence in all staff and were respected and treated as individuals.

Our key findings were:

- The centre had systems and processes in place which ensured patients were protected from abuse and avoidable harm.
- Patients' care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence.
- Staff involved, and treated, patients with compassion, kindness, dignity and respect.
- Services were organised so they met patients' needs.
- The leadership, management and governance of the organisation assured the delivery of high-quality; patient centred treatment and care, supported learning and innovation, and promoted an open and fair culture.
- Systems and processes required improvement for infection control, fire safety and equipment for dealing with emergencies when carrying out domiciliary treatment.
- Patients were kept waiting longer than the standard met when referred to the centre. However, there was a system in place to ensure patients with higher need were seen as a priority.

We identified regulations that were not being met and the provider must**:**

- Have in place records of what is expected of cleaners and records of schedules completed by the cleaners.
- Complete recommended actions following the legionella risk assessment to reduce risk to patients and staff using the access centre.
- Ensure immunisation status is recorded for all staff who have received hepatitis B immunisation as directed by the Code of Practice on the prevention and control of infections, appendix D criterion 9(f).

Summary of findings

- Ensure they take all the required emergency kit with them when undertaking domiciliary visits.
- Ensure patients are not kept waiting longer than the standard wait time for referrals.
- Ensure staff were recruited safely according to the Trusts recruitment policy and Schedule 3 of the Health and Social Care Act 2008. Particularly ensuring references and gaps in employment were evidenced during the recruitment process.

For full details of the regulations not being met please refer to the Somerset Partnership NHS Foundation Trust report dated 7-11 September 2015 – Community and Specialist Dental Services in order to see the areas for which requirement notices were issued.

There were areas where the provider could make improvements and should:

- The whistle blowing policy did not include information about who staff could raise concerns with externally such as the Care Quality Commission (CQC).
- Have in place all oropharyngeal airways including size 0.
- Review the effectiveness of the system to ensure accurate records of annual servicing of compressors for all sites are maintained and available to the centre manager .
- Individualise patient feedback to enable a clear view of patient satisfaction at individual access centres.
- Review whether training in learning disabilities is relevant and necessary due to high number of patients with a learning disability attending the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found this access centre was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details in the Somerset Partnership NHS Foundation Trust Community Dental Services report).

Systems, processes and practices were in place to ensure care and treatment was carried out safely. However, there were some areas that required improvement including for infection control and fire safety.

Lessons were learned and improvements were made when things went wrong. Systems, processes and practices were in place to keep patients safe and safeguard them from abuse. Risks to individual patients were assessed and their safety monitored and maintained.

Potential risks to the service were anticipated and planned for in advance and systems, processes and practices were in place to protect patients from unsafe use of equipment, materials and medicines. However, equipment available for emergency treatment for domiciliary visits needed to be reviewed to ensure the safety of patients.

Are services effective?

We found this access centre was providing effective care in accordance with the relevant regulations.

Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment. The access centre monitored patients' oral health and provided appropriate health promotion advice. There were effective arrangements in place for working with other health professionals to ensure effective quality of treatment and care for the patient. Patient's consent to care and treatment was always sought in line with legislation and guidance. Staff engaged in continuing professional development and were meeting the training requirements of the General Dental Council.

Are services caring?

We found this access centre was providing caring services in accordance with the relevant regulations.

We received very positive feedback from patients about the quality of care provided at the dental access centre. They felt the staff were patient centred and caring; they told us they were treated with dignity and respect at all times. Patients felt they were fully involved in decisions about their treatment and dental staff took the time to ensure they understood their treatment options. We found patient confidentiality was well maintained.

Are services responsive to people's needs?

We found this access centre was not providing responsive care in accordance with the relevant regulations. We have told the provider to take action (see full details in the Somerset Partnership NHS Foundation Trust Community Dental Services report).

Services were planned and delivered to meet the needs of patients. Routine patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of patients with a disability had been considered and arrangements had been made to ensure all patients could easily access the service for treatment. Information on complaints was available for patients.

Summary of findings

Referrals were organised to ensure patient needs were prioritised and met. However, the centre had a number of patients waiting longer than the set standard to receive treatment, so not all patients were receiving treatment at an appropriate time.

Are services well-led?

We found this centre was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details in the Somerset Partnership NHS Foundation Trust Community Dental Services report).

Governance arrangements ensured responsibilities were clear, quality and performance were regularly considered. Risks were identified but not always coordinated effectively to ensure recommendations were addressed promptly. For example, recommendations had not been completed or addressed following a legionella risk assessment to ensure the safety of patients.

The leadership and culture reflected the vision and values of the Trust. They encouraged openness and transparency and promoted the delivery of high quality care and treatment. Feedback from staff and patients was used to monitor and drive improvement in standards of care. The Trust had an effective process to inform staff about when policies were updated. The updates were discussed in staff meetings and a copy of the minutes was placed with the policy document to indicate when this information was shared with the staff.

Bridgwater Dental Access Centre

Detailed findings

Background to this inspection

The inspection was carried out on 8 September 2015 by a CQC inspector and a specialist dental advisor.

We asked Somerset Partnership NHS Foundation Trust to provide a range of information before the inspection about all their dental access centres. The information reviewed did not highlight any significant areas of risk across the five key question areas for Bridgwater Dental Access Centre.

On the day of our inspection we looked at policies and protocols, dental patient records and other records relating to the management of the service. We spoke with the senior dental nurse (who had responsibility for managing the centre), one dentist with a specialist interest in oral surgery, one general dentist, five dental nurses and a receptionist. We also reviewed 10 Care Quality Commission comments cards completed by patients and spoke with three patients.

We informed NHS England area team and Somerset Healthwatch that we were inspecting the practice and we did not receive any information of concern from them.

To get to the heart of patients' experiences of care and treatment, we always ask 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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

There was an effective system in place for reporting and learning from incidents. There was a policy for staff to follow for the reporting of these incidents and we heard from staff how this would be implemented when an incident happened. We were told of a sharps incident that had occurred with a member of staff; following which the protocol had been updated to provide clearer responsibility for dental staff regarding who should dispose of dental equipment.

Staff meetings were convened regularly, monthly formal meetings where held every month, and any points of learning from incidents were a regular agenda item. We were told this was where the wider learning points from an incident or audit could be disseminated and any necessary change in protocol discussed and passed to all staff. We saw in the minutes from August 2015 meeting reminders of how to report incidents had been discussed. For staff not present at the meeting the Senior Dental Nurse ensured they were updated with information shared at the meeting.

We noted it was the provider's policy to offer an apology when things went wrong. We saw the provider had a policy for 'being open and duty of candour' last reviewed in August 2015.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no accidents or incidents which had required notification under the RIDDOR guidance.

Reliable safety systems and processes (including safeguarding)

The provider had policies and procedures in place for child protection and safeguarding vulnerable adults. This included contact details for the local authority safeguarding teams and other agencies, such as the Police. This information was available for all staff via the provider intranet or internet site and could be accessed promptly. The contact details for safeguarding lead for the Somerset dental access centre's was not located within the providers safeguarding policy. However, we saw it was available to staff within staff communal areas.

The Somerset dental access centres had a lead paediatric dentist for safeguarding children based at the Taunton centre and a dentist lead for vulnerable adults at the Glastonbury centre. We were informed they had been appropriately trained to level three in child protection as identified in the national guidance called Safeguarding Children and Young People: roles and competences for health care staff, March 2014. All dentists and dental nurses who provided treatment at this access centre and all other staff had received level two training in child protection and this was provided on a three yearly basis.

Staff spoken with demonstrated to us their knowledge of how to recognise the signs and symptoms of abuse and neglect and knew how to report concerns internally through the organisation and externally. There was a documented reporting process available for staff to use if anyone made a disclosure to them. The access centre had confirmed there had not been any safeguarding referrals made in the last year.

The access centre also followed national guidelines about patient safety. For example, they used a rubber dam for root canal treatments. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth). They also had a latex free rubber dam for patients who were allergic to latex.

Medical emergencies

The access centre had arrangements in place to deal with medical emergencies. All staff had received annual intermediate life support training supplied by an external agency. If staff were unavailable to attend the training at Bridgwater dental access centre then they were able to attend on other dates at other access centres within the Trust. Staff spoken with understood their role if a medical emergency occurred.

The practice had suitable emergency equipment and medicines in accordance with guidance issued by the Resuscitation Council UK and British National Formulary (BNF). This included relevant emergency medicines, oxygen and an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). There were oxygen face masks for adults and children and different sized airways available except for size 0.

The Oxygen and AED was checked weekly and medicines were checked on a monthly basis by staff to ensure they

were in working order and a clear record of the checks and replacement equipment/medicines was kept. The checklist did not show specifically the AED was checked and we were informed this would be added to the checklist immediately in order to keep a record of these checks.

The access centre visited patients within their own home and within a residential or nursing home environment. The trust had a standardised kit that all dental access centres used in Somerset. We were informed that higher risk procedures, such as extractions were performed, when necessary. We were told domiciliary kits had been discussed at Trust level and the kit agreed. We noted the kit did not include a full emergency medicines kit, oxygen and an automated external defibrillator was not taken on visits as routine. This did not reflect the guidelines from The British Society for Disability and Oral Health, guidelines for the delivery of a Domiciliary Oral Health Service August 2009.

Staff recruitment

Staff were able to share different tasks and workloads when the practice entered busy periods for patients. Staff told us the levels of staff and skill mix were reviewed and staff were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy at times. For example, all dental nurses were trained in sedation and half of dental nurses who worked at Bridgwater dental access centre had training in radiology.

There were recruitment and selection procedures in place which were managed through the Human Resources department of the Trust. At the Trust Head Quarters we looked at 14 personnel files and saw in 10 of the 14 records information obtained and recorded was compliant with the relevant legislation. However in four files some key information was missing. For example immunisation status was not always recorded, or if immunisation status had been recorded as needing attention there was no clear process to identify who was responsible for ensuring appropriate action was taken and completed. We also saw that not all references received had been signed and gaps in employment had not always been explored and recorded.

A range of checks had been made before staff commenced employment including evidence of professional registration with the General Dental Council (where required) and checks with the Disclosure and Barring Service (DBS) had been carried out. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

Potential risks to the service were anticipated and planned for in advance to ensure patient and staff safety. We saw there was a health and safety policy in place. We saw the last fire risk assessment had been completed in March 2014 and were told they had just reviewed this in September 2015. Trust policy was to complete risk assessment annually. The access centre had one completed in March 2014 when they had moved sites but were overdue for their next assessment by six months.

We saw fire extinguishers were serviced annually and were last serviced in February 2014. We saw fire alarms were checked on a weekly basis and emergency lighting was checked on a monthly basis. Fire drills had not been completed at least annually as recommended by HTM05-03 for fire safety in the NHS. The last fire drill had been completed in March 2014 and the centre had a received an updated fire drill on the day of our inspection on 8 September 2015.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances which are hazardous to health. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise these risks. There was a person responsible for maintaining the file and disseminated information about how to minimise the risks associated with new products to staff before they were used.

The access centre had developed clear lines of accountability for all aspects of care and treatment. Staff were allocated lead roles or areas of responsibility for example, safeguarding, sedation and infection control.

There were systems in place to ensure patients' confidential information was protected. Dental treatment records were mostly stored electronically. The majority of

paper correspondence was scanned and added to the electronic record. Paper records that were kept were stored securely in locked cabinets. Electronic records were password protected and regularly backed up.

There were arrangements in place to deal with foreseeable emergencies. There was a business continuity plan in place, which provided guidance for staff in certain emergencies, such as severe weather, inadequate staffing levels and total loss of access to the building.

Infection control

During our inspection we saw the access centre appeared clean and was well maintained. The provider had recently employed a new contract cleaner and they had started in July 2015. The senior dental nurse was unable to supply us with a cleaning plan, schedule and checklists. They were following this up with the cleaning company to ensure records were held in the centre.

There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of personal protective equipment and domiciliary visits. One of the dental nurses was the lead professional for infection control within the access centre and demonstrated to us how changes had been made and implemented to ensure compliance with the appropriate guidance. There was also an overall dentist who took a lead role for infection control which covered all Somerset dental access sites and provided advice and guidance to staff from all sites.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05' Decontamination in primary care dental practices (HTM 01-05)'. The access centre had the facilities to meet best practice including separate decontamination rooms; one for cleaning dirty instruments and then a hatch through to the clean room where instruments were sterilised. In accordance with HTM01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between the dental chair and the decontamination area in the surgery which ensured the risk of infection spread was minimised. This system also included colour coding of instruments and trays so all rooms had their own instruments returned.

Dedicated hand washing facilities were available in both decontamination rooms including wall mounted hand soap, hand towels and moisturiser. In the dirty room there was one additional sink for scrubbing instruments if there was stubborn debris on them, which the washer disinfector could not remove, they were then placed back in the washer disinfector to repeat the process. There were two washer disinfectors (normally three, the third was in the process of being replaced). There were facilities to check instruments using an illuminated magnifier after they had been cleaned and were then packaged before being transferred into 'clean' room for sterilisation.

Staff spoken with understood their role when cleaning and sterilising instruments. We noted how the room was setup did not provide a clear flow from dirty to clean within the 'dirty' room. The washer disinfector was positioned at the end of the process rather than the packaging area. Following our inspection the Senior Dental Nurse had arranged for their facilities team to move this equipment within a week of our inspection.

We saw personal protective equipment was available for dental staff to use in wall mounted dispensers, including aprons and gloves, which were available in a range of sizes. In each surgery we saw there was a clear flow from 'dirty' to 'clean' around the room. One of the dental nurses demonstrated how they processed instruments and showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection.

We saw the two washer disinfectors and three vacuum autoclaves to clean and sterilise the instruments had received regular weekly checks according to manufacturer's guidance.

Staff explained to us the practice protocol for single use items and how they should be used and disposed. The methods described were in line with guidance. We observed the treatment rooms where patients were examined and treated. All rooms and equipment appeared to be clean, well maintained and clutter free.

The access centre normally carried out six monthly infection control audits. We saw the last two audits completed; one in August 2014 and the other in February 2015. The centre was currently overdue for the next audit. However, compliance with the standards was found to be high and action plans were in place from the last audit for

areas to improve upon. It was noted the initial audits seen for Bridgwater, Minehead and Burnham on Sea from August 2014 did not include actions plans of areas to improve. However, results were either 97% or 98% for audits.

We observed how waste items were disposed of and stored securely. The access centre had a contract for the removal of clinical waste. We saw the differing types of waste were safely segregated and stored securely outside the access centre.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM01-05 guidelines.

We saw a Legionella risk assessment had been completed in May 2014 by an appropriate contractor. We saw there were a number of recommendations from this risk assessment but from the checks seen these were not completed, such as monthly checks of hot and cold water temperatures which demonstrated the water was within the required temperature to prevent the growth of Legionella.

Staff files showed staff had last attended training for infection prevention and control in March 2015. All clinical staff were expected to complete this annually. Dentists and dental nurses were required to produce evidence to show they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Records seen confirmed this for most staff.

There were hand washing facilities in each surgery and staff had access to good supplies of personal protective equipment (PPE) for patients and staff members. Staff and patients we spoke with confirmed staff wore protective aprons, gloves and masks during assessment and treatment in accordance with infection control procedures.

Equipment and medicines

There were sufficient quantities of instruments and equipment to cater for each clinical session which took into account the decontamination process. We saw the annual servicing records for all three sites; Bridgwater, Burnham on Sea and Minehead, including the suction compressor and autoclaves. However, records for the compressor service for Bridgwater could not be found and so an additional service had been arranged for the week following our inspection.

The records showed the service had a system in place to ensure all equipment in use was safe, and in good working order. However, this could be further improved to ensure all records were safely held for all sites to evidence servicing had occurred.

An effective system was in place for the prescribing, recording, dispensing, use and stock control of the medicines used in clinical practice such as local anaesthetics. The systems we viewed were complete, provided an account of medicines used and prescribed which demonstrated patients were given medicines only when necessary. The batch number and expiry date for local anaesthetics were recorded on individual patient records. These medicines were stored safely and securely.

Radiography (X-rays)

Radiography equipment was available in all of the three treatment rooms. The access centre had a Orthopantomogram (OPG) and three digital X-ray machines which were serviced every three years as described in manufacturers guidance. The OPG X-ray was located in a specific X-ray room whilst the others were located in each treatment room.

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). There was a well-maintained radiation protection file, in line with these regulations. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive.

We saw evidence staff had either completed radiation training, or were booked on to an appropriate course to renew their training in 2015. We reviewed a sample of dental care records where X-rays had been taken. These records showed dental X-rays were justified, reported upon and quality assured every time. The access centre carried out regular six monthly audit for all dentists working in the centre to review their X-ray performance. The last audit seen demonstrated X-rays were being taken to an appropriate standard. These findings showed the practice was acting in accordance with national radiological guidelines so patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The access centre carried out patient consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We saw treatments were planned and delivered in line with patient's individual treatment plans. Two of the dentists described how they carried out patient assessments and we reviewed a sample of the dental care records. We found the dentists regularly assessed patient's gum health and soft tissues (including lips, tongue and palate).

The records showed an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action. Details of the treatments carried out were also documented including; local anaesthetic details including type, site of administration, batch number and expiry date were recorded.

The reception staff gave all new patients a medical history form to complete prior to seeing the dentist for the first time. The dentists' notes showed this history was reviewed at each subsequent appointment. This kept the dentist reliably informed of any changes in each patient's physical health which might affect the type of care they received.

Patients we spoke with and comments received reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and the outcomes of the treatment provided.

Patients' dental recall intervals were determined by the dentists using a risk based approach based on current National Institute for Health and Care Excellence (NICE) guidelines. The recall interval for each patient was set following discussion of these risks with them.

The dentists worked according to the NICE guidelines in relation to deciding antibiotic prescribing and wisdom teeth extraction The dentists were also aware of the 'Delivering Better Oral Health Toolkit' when considering care and advice for patients. 'Delivering Better Oral Health' is an evidence-based toolkit to support dental teams in improving their patients' oral and general health.

The dentists were informed by guidance from the Faculty of General Dental Practice (FGDP) before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded in the patient's treatment record. The dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP).

The trust ran a dental Help and Advice line which operated daily between 8.30am until 6.00pm. Outside of these hours patients were directed to call NHS 111. The service had access to all the NHS emergency dental appointments across Somerset for each day and Saturday appointments at one of the dental access centres for patients with acute pain.

All calls to the service are triaged by an experienced call handler and appointments booked. There is always an on call dentist for clinical back up and advice. Feedback from patients who used the service told us it was excellent and ensured they could get an urgent appointment when they had dental pain.

Health promotion & prevention

The reception area contained leaflets which explained the services offered at the access centre. The practice had a range of products patients could purchase that were suitable for both adults and children.

Our discussions with the dentists and review of the dental care records showed that, where relevant, preventative dental information was given in order to improve outcomes for patients. This included advice around smoking cessation, alcohol consumption and diet. Additionally, all the dentists carried out checks to look for the signs of oral cancer.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to patients in a way they understood. Oral hygiene and dietary advice had been discussed with the use of appropriate demonstrations.

Staffing

Are services effective?

(for example, treatment is effective)

Staff told us they received appropriate professional development and training. Continuing professional development was reviewed centrally within the Trust to monitor dentists and dental nurse's progression. Professional registration was also reviewed and highlighted to staff when they were due for review by the General Dental Council. We reviewed training records for all dental nurses and reception staff and saw staff were up to date with their training. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to medical emergencies, safeguarding, consent and infection control. There was an induction programme for new staff to follow to ensure they understood the protocols and systems in place with the Trust and access centre.

Appraisals were completed annually for all staff and in addition to this staff received six to eight weekly supervisions. The Senior Dental Nurse would appraise the dental nurses and reception staff and included a review of their continuing professional development and training completed. Staff were encouraged to develop their role and were supported to complete additional training, such as a high number of patients used sign language to communicate, so a number of dental nurses had been trained in sign language. Half of the dental nurses employed had completed a radiography qualification to further assist the dentists. We heard how the receptionist had been encouraged to completed a business level three course to help support and assist them with their day to day role.

The access centre had a high number of patients visiting who had a learning disability and dementia. The provider supplied training for understanding dementia within staffs induction but not learning disabilities. Staff spoken with felt this was not an issue but could be useful to have some additional training in this area to improve understanding of their condition and communication with people with a learning disability.

Working with other services

The majority of patients were referred to the access centre from general dental practices within the local area. Referrals were assessed and monitored by the Trust and were refused on a case by case basis. Where a theme was established of rejected referrals for particular dentists or dental practices the clinical director would follow this up with the specific practice to improve referral quality received and understanding of the referring dentist.

Bridgwater dental access centre worked with the other three access centres run by the Trust to share learning and monitor areas of treatment received. Regular meetings were held with senior management to ensure there was a consistent approach at each site. Also, referrals were often made by Bridgwater dental access centre if they were unable to meet the patients' needs, for example, they may refer to the hospital or another access centre for more complex treatment needing general anaesthetic or intravenous sedation.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the patient's treatment records. Formal written consent was also obtained using standard consent form particularly when they were providing treatment for sedation or minor surgery. Patients were asked to read and sign these before starting or receiving a course of treatment.

Staff confirmed the requirements of the Mental Capacity Act 2005 (MCA) had been considered by the access centre staff. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentists spoken with could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from 13 patients; three visiting the practice and 10 comment cards. They all described a highly positive view of the service provided. Patients commented staff were always helpful and considerate. Patients particularly noted staff were sympathetic, compassionate and reassuring when they were nervous or had a phobia of dentists and this helped to put them at ease.

During the inspection we observed staff in the reception area. They were polite and courteous towards patients and the general atmosphere was welcoming and friendly. Patients commented where they had not had a good previous experience from visits to general dental practice and how their confidence had grown in dentistry since using this service. They said this was because of how staff treated them as individuals and showed they cared about them to make their experience a positive one.

Staff and patients told us dental treatments were carried out in the treatment rooms and doors were closed during their appointment and conversations taking place in these rooms could not be overheard. We observed patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. We also observed staff dealing with patients on the telephone and saw them respond in an equally calm professional manner. Staff spoken with were aware of the importance of protecting patient confidentiality and reassurance for nervous patients. Reception staff told us patients could request to have confidential discussions in a private area of the practice, if necessary.

The access centre obtained regular feedback from patients via the friends and family test. The results from this were analysed centrally and included results from all other access centres. We were unable to determine this dental access centres results. Although the results overall for all Somerset Dental Access centre sites were high in patient satisfaction.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which provided details of the NHS dental charges and fees as well as how patients could get help for the costs of treatment. There was a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We reviewed a sample of dental treatment records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with two dentist's and five dental nurses on the day of our inspection. They understood the importance of providing clear explanations of treatments and costs in order to promote a shared decision-making process with their patients. They also showed us how they used written information, models and computer screens to provide visual and written prompts. Staff described to us how they had supported patients with additional needs such as a learning disability. They ensured patients were supported by their carer or a relative and there was sufficient time to explain fully the treatment they were providing in a way patients understood.

The patient feedback we received via discussions and comments cards, confirmed patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions of treatment provided by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the access centre was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We observed appointments ran smoothly on the day of the inspection and patients were not kept waiting. The access centre had a system in place to schedule enough time to assess and meet patients' needs. Each referral provided information on why the patient was visiting and any communication difficulties they may have this enabled the access centre to determine how long the patient may need for an assessment.

The majority of patients were seen in the access centre from a referral from a general dental practice. In exceptional circumstances patients were also seen for general dentist appointments. Staff told us they had enough time to treat patients. The feedback we received from patients confirmed they could get an appointment within a reasonable time frame and they had adequate time scheduled with the dentist to assess their needs and receive treatment.

Tackling inequity and promoting equality

The access centre had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and as individuals. Patients were welcomed patients from a range of different backgrounds, cultures and religions. Patients could visit the access centre if they had difficulty in accessing general dental practices, required domiciliary visits, such as visits in a residential or nursing homes or were housebound. Patients with dental phobias or who had a dementia or learning disability were visits to general dentists had been unsuccessful.

We were told the access centre had access to a translation service and they could request a translator to visit with the patient for their appointment. Some information leaflets were also written in Polish as this was the main second language in the local population. There was also a number of dental nurses trained in sign language, as this had been a determine need for patients visiting the access centre. There was a hearing loop for patients who were hard of hearing as well as large print documents for patients with some visual impairment.

The access centre had considered the needs of patients with mobility issues. There was allocated disabled parking spaces, a ramp upon entry to the building to enable wheelchair access for patients with mobility difficulties. If patients who used wheelchairs were unable to access areas of the practice then a suitable side entrance could be used to access these areas. All treatment rooms were on the ground floor and there was an accessible toilet. The reception and waiting areas were accessible to all patients; this included a lowered reception desk and alternative seating, such as armed chairs, high back padded chairs and space for wheelchair access.

Access to the service

The access centre was open from Monday to Friday 8:30am to 12:30pm and 1:30pm to 5pm. The access centre displayed its opening hours outside their premises and on the NHS choices website. We noted opening hours were not included on the Trust website. The out of hour's service was run by the Trust and was based at Bridgwater dental access centre called Somerset Dental Advice Line. They were open from 8am to 8pm Monday to Friday and weekends and bank holidays were open from 8:30am to 6pm. Weekend out of hours pain relief was run by general dentists in the local area.

Because the access centre had a small number of general dentistry patients there was an allocated urgent appointment slot for everyday for patients in pain. Also, routine appointments were planned in to the appointments schedule alongside referral appointments.

The access centre had to meet a standard for patients referred to be seen within an 18 week period. In September they currently had a waiting list of 124 patients that had passed this timeframe. This had decreased from 171 referrals in June. There had been a number of changes of staff including vacancies; staff career progression either within the Trust or externally and long term leave. Also, there had been a number of inappropriate referrals made by general dental practitioners; these were followed up by clinical director to improve referral levels. Referrals were generally higher for this site due to the vulnerability of the

Are services responsive to people's needs?

(for example, to feedback?)

patients in the area. We saw Taunton access centre had higher referrals received and a lower number of patients who were over the 18 week period. This was because the Taunton site did not have any vacancies for dentists.

The access centre had a number of patients who did not attend their appointments which was affecting the length of time other patients had to wait to be seen. The access centre had acknowledged this was an area they needed to improve upon and had made a number of changes to try and decrease the number of 'do not attend' (DNA).

All patients were called the day before their appointment to remind them. If patients did not attend an appointment they would either be sent a letter or would be called from one of the reception team members. As there was sometimes a long wait between referral from the general dental practice and being seen by the access centre sometimes patients address details had changed, so to ensure patient details were correct before sending the initial appointment letter the patient was phoned to check their personal details.

Following these changes the access centres for all three sites had seen a steady decrease in DNAs since March 2013. For example, March 2013 showed there were 73 DNAs and March 2015 there were 25 DNAs for the Bridgwater site.

Concerns & complaints

There was a complaint policy which described how the practice handled formal and informal complaints from patients. Patients told us if they needed to complain they would approach staff for the information. Information about how to make a complaint was on the Trust website.

Complaints were logged onto the Trust database and forwarded to the Head Quarters support team. Complaint letters from patients were uploaded to the database in order to ensure they were kept secure. The centre manager was supported by the complaints department who were able to advise the best way forward and the correct process to follow.

There had not been any complaints received in the past year. The Senior Dental Nurse told us patients routinely received a written response, including an apology, when anything had not been managed appropriately. For a service with such compromised patients the level of formal complaints is very low (compared with high street practice).

The Trust had a policy in relation to raising concerns about another member of staff's performance (a process sometimes referred to as 'whistleblowing'). Staff told us they knew they could raise such issues with one of the dentists or Senior Dental Nurse or senior management. The whistle blowing policy did not include information on who they could raise concerns to externally such as the Care Quality Commission (CQC).

Are services well-led?

Our findings

Governance arrangements

Governance and performance management arrangements were proactively reviewed and reflected best practice. The Trust had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the access centre. The policies and procedures we reviewed were updated regularly and reflected current guidance and legislation. Senior dental staff met regularly to discuss best practice and make decisions on updating relevant policies according to changes in new guidance.

There was a clear leadership structure for the Somerset dental access centres with named members of staff in lead roles. For example, there was a lead professional for infection control, safeguarding vulnerable adults and children, radiation, sedation and clinical audits. Staff spoken with were clear about their own roles and responsibilities. They all told us they felt valued, well supported by management and knew who to raise concerns with in the access centre and externally within the Trust.

The Trust did not always implement nationally recognised guidance in respect of domiciliary visits and emergency treatment. The trust had a standardised kit that all dental access centres used in Somerset. We were informed domiciliary kits had been discussed at Trust level and the kit agreed. We noted the kit did not include a full emergency medicines kit, oxygen and an automated external defibrillator was not taken on visits as routine. This did not reflect the guidelines from The British Society for Disability and Oral Health, guidelines for the delivery of a Domiciliary Oral Health Service August 2009.

Leadership, openness and transparency

The ethos of the Trust was caring for you in the heart of the community. There was a commitment to quality care, dignity and respect, compassion, improving lives, everyone counts and working together for patients.

Staff spoken with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with any of the dentists, their line manager and senior management. They felt they were listened to and the senior management team responded when they raised issues of concern or suggestions for improvement.

We saw from minutes of team meetings they were held regularly. Each meeting had an agenda that was variable but included updates and information about subjects such as infection prevention and control, clinical audits and health and safety. We saw completed audits which included aspects of health and safety, radiography and infection control.

There were clearly defined leadership roles within the practice. There was a Trust administration team that ensured human resource and clinical policies and procedures were reviewed and updated to support the safe running of the service. These included guidance about confidentiality, record keeping, incident reporting and consent to treatment.

We reviewed a number of policies which were in place to support staff. We were shown information was available to all staff which included equal opportunities, confidentiality and staff employment policies. For example whistleblowing, harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Learning and improvement

Staff told us they enjoyed their work and were well supported by the Trust, dentists and management. Staff were regularly appraised and received regular supervisions to aid their learning and improvement.

All staff were supported to pursue development opportunities. We saw evidence staff were working towards completing the required number of continuing professional development (CPD) hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice had a programme of clinical audit and risk assessments in place. These included audits for infection control, clinical record keeping, sedation, oral surgery and X-ray quality which showed a generally high standard of work.

Risk assessments were not always successfully used to minimise the identified risks. For example, required recommendations were not followed from the legionella risk assessment. Fire procedures were not always

Are services well-led?

completed within the correct timescale, for example, the fire drill was completed after 18 months not annually as described in national guidance and the fire risk assessment was not reviewed annually as described in the Trust policy. The system for monitoring annual servicing was not always effective as there was no check to ensure all locations were serviced at the required intervals and records held.

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

Patients expressed their views and were involved in making decisions about their care and treatment. The Trust used the friends and family test to monitor patient satisfaction. The data was captured centrally for all dental access centre locations in Somerset. Information sent to individual centres included all dental access centre feedback and not individual location and so was difficult to determine patient satisfaction at individual sites and use this to improve the service.

The three patients we spoke with were very happy with the standard of treatment they had received. They described the access centre staff as helpful and friendly. Patients were satisfied with appointment waiting times and the cleanliness of the practice. This was further supported by the 10 completed Care Quality Commission comment cards.

The practice had gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.