Somerset Partnership NHS Foundation Trust

Taunton Dental Access Centre

Inspection Report

Parkgate House
East Reach
Taunton
Somerset
TA1 3ES
Tel:01823 346116
Website: www.sompar.nhs.uk

Date of inspection visit: 9 September 2015
Date of publication: 17/03/2016

Overall summary

We carried out an announced comprehensive inspection on 9 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

Taunton 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 into 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 was a 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 and 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 5pm Monday to Friday. Appointments are generally by referral only, although in exceptional circumstances patients can be seen regularly for general dentistry, there is 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 and intravenuous 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.

Taunton dental access centre has two satellite services based in Wellington and Chard. .At the Wellington site they normally open on a Monday and Tuesday for special care dentistry and inhalation sedation services. At the Chard site they normally open Mondays, Thursdays and Fridays providing special care dentistry and inhalation sedation. Taunton dental access centre is providing additional cover for appointments and domiciliary services to cover the suspension of two satellite services in Burnham-on-Sea and Minehead.

Taunton dental access centre had previously been inspected on 29 July 2013 and was found compliant with the relevant regulations at the time.

We spoke with one patient and one carer during the inspection who provided feedback about the service; we did not receive any Care Quality Commisson 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**:**

- Be carrying out fire drills and fire risk assessments at appropriate intervals according to the provider's policy and national guidance.
- 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).
- Ensure when carrying out domiciliary visits they take appropriate emergency equipment as advised by the British Society for Disability and Oral Health (BSDH) August 2009.
- 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.

Summary of findings

- Ensure all equipment is regularly serviced in line with approved guidance.

You can see full details of the regulations not being met at the end of this report.

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

- Should ensure the centre manager and senior clinician is empowered to make local decisions in the best interest of Taunton DAC.
- The whistle blowing policy did not include information about who staff could raise concerns with externally such as the Care Quality Commission (CQC).
- 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 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.

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 placed with the policy document to indicate when this information was shared with the staff.

Taunton Dental Access Centre

Detailed findings

Background to this inspection

The inspection was carried out on 9 September 2015 by a specialist dental advisor who had access to advice from a CQC inspector.

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 Taunton 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 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

Reporting, learning and improvement from incidents

The Senior Dental Nurse told us about two incidents that had occurred within the last year. We heard one of the incidents was when the door of a washer-disinfector had flown open during use. Staff were not injured during the incident. The access centre had taken action to ensure the equipment was safe to use by an appropriate company before being used again. The Senior Dental Nurse ensured all relevant staff in the Trust were informed of the incident promptly and an incident form was completed. The incident had been discussed at a centre meeting so all staff were aware of it and learning from the incident could be shared.

In the second incident a "never event" had occurred when the wrong tooth was extracted from a patient in error. The tooth that was extracted also was due to be extracted at a later date but was not the cause of the patient's pain at the time. The patient was informed of the error and received an apology. Since this event the protocols regarding extraction of teeth have been changed. A surgical checklist has been implemetned and the tooth/ teeth to be extracted were now first confirmed with the patient and the treatment plan by the dentist and then double checked by the dental nurse in attendence.

The access centre had an appropriate accident record book and incident policy in place. The Senior Dental Nurse told us there had not been any sharps injuries recently following the introduction of a policy where the dentists dealt with their own sharps such as local anaesthetic syringe needles and scalpel blades.

Reliable safety systems and processes (including safeguarding)

We saw evidence there was recognition of the value of shared learning when things went wrong. There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). The access centre used dental safety syringes which meant needles were disposed of safely and this complied with the Safe Sharps Regulations 2013.

The access centre manager understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and confirmed no reports had been made.

The Senior Dental Nurse told us the names of the two dentists appointed as Safeguarding lead professionals for children and adults respectively. They would attend meetings regularly with other Safeguarding lead personnel within the Trust. Information would be distributed by email if urgent or otherwise ar the next clinical meeting. Meetings were held montly. Staff we spoke with were aware of the names of their Safeguarding lead professionals and the Trust Safeguarding Policy which was available on the Trust website. Safeguarding training was part of the mandatory training for the clinical staff and also formed part of the induction process for new staff. We spoke with several staff who were all aware of where to find the contact numbers for the various safeguarding agencies.

We asked how the location treated the use of instruments which were used during root canal treatment. We observed root canal instruments were of single use and disposed of after root canal work in line with current guidance. We observed the access centre kept in each surgery an extensive stock of materials and equipment used for root canal treatments. Root canal treatment was carried out where practically possible using a rubber dam which we observed was latex free. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured the practice followed appropriate guidance from the British Endodontic Society in relation to the use of the rubber dam.

The Senior Dental Nurse described how patients were allowed to choose their own appointment (rather than being allocated one) in an attempt to reduce the number of failed appointments. They were also reminded by telephone the day before their appointment. The Senior Dental Nurse told us this was particularly important as many of their patients are afraid of dental treatment and are unwilling to access dental treatment elsewhere.

Medical emergencies

The access centre had arrangements in place to deal with medical emergencies. These were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Appropriate emergency equipment including portable oxygen and an Automated External Defibrillator (AED) were available. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical

shock to attempt to restore a normal heart rhythm). Appropriate medicines for use in an emergency were available according to the British National formulary. All emergency equipment and medicines were stored in a central location.

The Senior Dental Nurse showed the kit available for dealing with any medical emergencies that may arise. All the drugs and equipment in the kit were in-date and there was a system in place for checking this on a daily basis. Oxygen and equipment for delivering it were also available in the clinic. Reserve cylinders of oxygen were also on site as part of the sedation equipment.

Records showed checks were made to help ensure the equipment and emergency medicine was safe to use. The expiry dates of medicines and equipment were monitored using a weekly check sheet which was signed by a member of staff. Therefore staff were familiar with the content and were able to replace out of date or used medicines and equipment promptly.

Staff had completed annual training in emergency resuscitation and basic life support. Staff we spoke with knew the location of the emergency equipment and how to use it.

One of the dentists told us the emergency drug kit (with the exception of an Epipen – injectable adrenaline), oxygen and AED were not taken when going on a domiciliary visit. We were told an informal risk assessment was always done to check the facilities available and assess the appropriateness of carrying out treatment away from the dental surgery. Most of the treatment involved examining the patient's mouth and providing dentures. Rarely would teeth extractions be carried out in the patient's home.where facilities to treat a medical emergency would not be available.

Staff recruitment

There were recruitment and selection procedures in place which were managed through the Human Resources department of the Trust. At the Trust HQ 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.

Staff told us there were usually enough staff to maintain the smooth running of the centre and there were always enough staff on duty to keep patients safe. We saw records that demonstrated staffing levels and skill mix were in line with planned staffing requirements.

Monitoring health & safety and responding to risks

The access centre had arrangements to deal with foreseeable emergencies. A health and safety policy was in place for the practice. The access centre had a log of risk assessments. For example, we saw current risk assessments for radiation, electrical faults and fire safety. The assessments included the measures which had been put into place to manage the risks and any action required.

The access centre had a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants and dental clinical materials. It also included details of blood and saliva and how to deal appropriately and safely with any spillage. The file did not have a review date on it to ensure all information contained within it was current and in accordance with latest product guidance.

We saw there were three autoclaves and two washer-disinfectors housed in the dedicated decontamination room. We were shown the service history and annual testing documents for all these pieces of equipment. A dental (air) compressor was also used in the clinic; however the Senior Dental Nurse told us there were no records at the centre to evidence testing of the equipment for its safety and efficacy. We were told these records are held at the Trust headquarters.

Are services safe?

We were shown the system for emergency lighting and the smoke detectors. There were a number of wall-mounted fire extinguishers throughout the clinic. The staff had undertaken fire training the day previous to the inspection and the fire alarms were tested on the day of our visit. Those members of staff who were absent from the training would be asked to undertake online training. While this is a form of training it is not specific and relevant to the location and there had been no fire drills in the last 12 months.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM 01-05) published by the Department of Health, sets out in detail the processes and practices which are essential to prevent the transmission of infections. During our inspection, we observed processes at the access centre which assured us the HTM01-05 essential requirements for decontamination had been met. The Trust had an infection control policy and a set of procedures which included hand hygiene, managing waste products and decontamination guidance.

We looked around the premises during the inspection and found all areas to be visibly clean. This was confirmed by the patient we spoke with and from the patient feedback forms to the centre which we reviewed. Treatment rooms were visibly tidy and free from clutter. Daily surgery checklists were in place which included cleaning and the flushing of dental unit water lines in line with published guidance in HTM01-05.

There were designated hand wash basins in each treatment room and the decontamination room. Instruments were stored and packaged appropriately in treatment room drawers.

Decontamination was carried out in a dedicated local decontamination room which we found met essential requirements of HTM01-05. We saw a clear separation of dirty and clean areas. There were adequate supplies of personal protective equipment such as face visors, aprons and gloves. Posters about good hand hygiene and decontamination procedures were displayed to support staff in following practice procedures. The centre had systems in place for the daily quality testing of decontamination equipment. Records confirmed these had taken place.

The Senior Dental Nurse carried out an Infection Prevention Society (IPS) self-assessment decontamination audit annually and not six monthly as required by the infection Prevention Society and in line with HTM01-05 requirements. This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We were told the last audit had been completed in July 2015. However no documentation for this date was available. We were shown the previous audit dated January 2014 which showed all actions required from the audit had been completed. The clinic had a dedicated decontamination room and complied with the requirements of HTM 01-05 from the Department of Health.

The Senior Dental Nurse described how the clinic was cleaned daily by external cleaners. The clinic was clean throughout.

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 was stored and segregated into safe containers in line with the Department of Health guidance. Sharps containers were well maintained and correctly labelled.

Contaminated clinical waste was collected in orange bags in the surgeries and then added by the cleaners to waste from the other departments in the building. It was then stored in three large lockable yellow bins housed in a caged area next to the back of the building awaiting regular collection by an external contractor. Another external collector picked up amalgam and tooth waste on a quarterly basis.

The Senior Dental Nurse showed us the Trust waste policy and an additional dedicated policy for the disposal of waste produced during domiciliary visits. We saw both the Trust policy and the Somerset Primary Care Dental Service policy about infection control included the management of sharps injuries. These were comprehensive and were included in the induction material seen by all new clinical dental staff.

Equipment and medicines

There were sufficient quantities of instruments and equipment to cater for each clinical session which took into

account the decontamination process. There were systems in place to check and record equipment was in working order. These included annual checks of portable appliance testing (PAT) of electrical equipment.

An effective system was in place for the prescribing, recording, dispensing, use and stock control of the medicines used in the access centre such as local anaesthetics and drugs used for sedation purposes. The systems we viewed were complete, provided an account of medicines used and prescribed which demonstrated patients were given medicines only when necessary.

Dentists recorded the batch numbers and expiry dates for local anaesthetic cartridges and these were recorded in the clinical notes. Medicines and prescription pads were stored securely and NHS prescriptions were stamped with an official centre stamp. Medicines stored in the centre were reviewed regularly to ensure they were not kept or used beyond their expiry date.

We saw the machine used to give Inhalational Sedation ("gas and air") had been serviced by an approved external contractor in April 2015. Intravenous sedation drugs (Midazolam and its reversal agent Flumazenil) were kept in a locked area away from the patient areas. We saw the Controlled Drugs book was kept securely in a safe and it contained separate sections for the different drugs used and their different types of administration, both intravenous and intranasal. A senior dentist explained each entry in the book which had all the required data recorded.

The Senior Dental Nurse told us the computerised records were backed up every evening and the computers were password protected to ensure patient records were safely stored. The paper parts of the patient records were kept in locked cabinets behind reception. These records included those completed during domiciliary visits.

Radiography (X-rays)

The access centre was working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). An external radiation protection advisor had been appointed and a nominated dentist was the radiation protection supervisor for the centre.

We were shown the current Radiation Protection File for the clinic. The clinic had both intra-oral and extra-oral (panoramic) X-ray machines. The names of the Radiation Protection Adviser and the Radiation Protection Supervisor were included in the Radiation Protection File together with the local rules, details of maintenance and testing of the X-ray machines and training of the dental staff. This was supplemented by the latest servicing documents for the machines seen at the Trust headquarters.

We analysed four of the patient (computerised) clinical records and saw the justification, technical quality and reporting of x-ray exposures was recorded in these records. The Senior Dental Nurse informed us the radiographs were audited on a regular basis but the result of such an audit were not available at the access centre.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients we spoke with and comments noted in the access centre's comments book reflected patients were very satisfied with the assessments, explanations and the quality of dentistry and outcomes of the treatment provided.

An inhalation sedation service where treatment under a local anaesthetic alone is not feasible and conscious sedation is required was delivered according to the standards set out by Intercollegiate Royal Colleges Guidelines for Conscious Sedation 2015. The sedation care was prescribed using an approved care pathway approach.

The location carried out consultations, assessments and treatment in line with recognised general professional guidelines. A review of a sample of dental treatment records and discussions with the two clinicians on duty confirmed this. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits.

This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients and/or their carers were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and/or carers and treatment options explained in detail. Observation of treatment sessions confirmed the approach described above was being carried out.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient dental treatment record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and/or carer and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements. A review of a sample of dental care records showed the findings of the assessment and details of the treatment carried out were recorded appropriately.

The Senior Dental Nurse told us they did audit their clinical records and the quality of radiographs but the results were not kept at the clinic.

Health promotion & prevention

Preventive care across the service was delivered using the Department of Health's 'Delivering Better Oral Health Toolkit 2010'. Adults and their carers attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood. Across the sample of dental care records reviewed we observed all demonstrated the dentist had given oral health advice to patients.

Taunton Dental Access Centre is supported in the promotion of oral health by an exceptional team located at the Burnham-on-Sea satellite clinic which we inspected during the course of the Trust inspection. The Senior Nurse told us they were hampered in their efforts at health promotion as they had no noticeboard space available in the centre.

Staffing

At the Taunton Dental Access Centre there was a team of dentists, dental nurses, and reception staff. Support staff at the practice had completed appropriate training. Clinical staff had attended continuing professional development training which was required for their registration with the General Dental Council (GDC).

The Senior Dental Nurse described the current situation with regard to recruitment of dentists. They told us staff who had left were not replaced quickly enough which was having an adverse effect on the patient waiting list. They demonstrated this by showing us how the numbers of patients waiting longer than 18 weeks for treatment had risen. They said the situation had deteriorated recently as two dentists had left. One of the receptionist staff also told us this.

A new dentist started at the access centre on the day of our visit. One of the dentists told us the appointment of a specialist dentist in special care dentistry was needed. There were no vacancies for dental nurses at the access

Are services effective?

(for example, treatment is effective)

centre. We saw records of the induction process planned for this dentist which were comprehensive, well-organised involving mandatory training at the Trust and shadowing of other dentists at a number of the dental access centres over a four week period. The dentist told us they felt they had been well-supported during the induction period so far.

Staff explained the annual appraisal process which involved their having an interview with their line manager and the production of a Personal Development Plan. They also described the more informal one-to-one meetings they had with their manager regularly. Dental nurses and dentists both told us how they had been encouraged to develop their skills through going on training courses and study, for example qualifications in dental sedation and radiography for the dental nurses and upgrading IV sedation skills for a dentist.

The Senior Dental Nurse showed us evidence of current training programmes available to staff. This included mandatory training such as safeguarding (level 2 for children and adults), infection control, intermediate life support, fire training and moving and handling. In addition there was more specific training available such as dementia training, drug and alcohol, autism, dual sensory impairment, mental health and young people; and prevention and management of violence and aggression. Specific training for learning disability was not available.

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.

Patients were sometimes referred to the local hospital for complex oral surgery, treatment under general anaesthetic and orthodontics, or to specialist services in Bristol for oral medicine and complex restorative cases. Dedicated referral forms were used and the patient given a copy of any referral letter.

We observed, and staff we spoke with told us, there was effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Effective MDT meetings, which involved dental staff, social workers, safeguarding leads, where required, ensured the patient's needs were fully explored.

Consent to care and treatment

Staff described the methods they used to ensure patients had the information they needed to be able to make an informed decision about treatment. We saw treatment options; risks, benefits and costs were discussed with each patient and documented in a written treatment plan. Staff explained to us how valid consent was obtained from patients at the practice. We reviewed a random sample of seven patient records which confirmed valid consent had been obtained. However, we observed from examining the complaint file which was held centrally at Trust HQ written consent was not always obtained.

Patients told us they were given time to consider their options and make informed decisions about which option they wanted. This was reflected in comments from patients with whom we spoke. One dentist showed us the care plan form used for domiciliary visits. This form was carbonated so the patient could have a copy as part of their overall care record.

Pre-treatment and pre-sedation consent forms were used as well as pre-general anaesthetic forms where appropriate. These forms were signed by the patient or carer and by the treating dentist. There was also space for a second dentist involved in the treatment to sign (if appropriate).

Staff we spoke with were aware of the Mental Capacity Act 2005 and where to find the Trust policy.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us they were treated with compassion, kindness, dignity and respect. Due to the nature of the patients treated on the day of our visit it was only possible to speak to one patient and one carer (of another patient). Both were very complimentary of the service and said how well they had been treated. The patient told us how they had been very scared of having dental treatment but now they were having treatment under inhalational sedation ("gas and air") which had involved the extraction of teeth on several occasions. The carer said the person she accompanied would not have come for treatment if they had not been happy to do so.

CQC Comments Cards were available in reception around the time of the visit but none were completed.

We observed patients were dealt with in a kind, friendly, compassionate and professional manner. We observed staff being polite, welcoming patients by their preferred name, being professional and sensitive to the different needs of patients.

Staff and patients told us all consultations and treatments were carried out in the privacy of treatment rooms to maintain patients' dignity and privacy. On the day of inspection we observed treatment room doors were closed at all times whilst patients were with dentists. Conversations between patients and their carers and dentists could not be heard from outside the rooms which protected patient's privacy. Patients' treatment records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable metal filing cabinets. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

We observed the dentists and the dental nurses treating patients and carers with dignity and respect. We saw they took extra time with patients who did not have full capacity to understand the advice being given. The dentists and support staff were skilled at building and maintaining respectful and trusting relationships with patients and their carers. The dentists sought the views of patients and carers regarding the proposed treatment and communicated in a way which ensured patients with a learning disability were not discriminated against. For example, patients and carers were given choices and options about their dental treatment in language they could understand.

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 patient described to us how the options for their treatment was explained to them clearly and they felt involved in decision making about the treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

We saw that before treatment commenced patients signed their treatment plan to confirm they understood and agreed to the planned treatment. Staff told us they involved relatives and carers to support patients in decision making when required.

Patients were given a copy of their treatment plan and for non-exempt patients the associated costs of the treatment planned. We found planned care was consistent with best practice as set down by national guidelines. Patients were informed of the range of treatments available and their cost in information leaflets. We saw NHS charges were clearly displayed in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The Taunton Dental Access Centre provided patients with information about the services in leaflets available at reception. We saw there were leaflets for specific treatments such as root canal, and oral hygiene. We found services were planned and delivered to meet the needs of patients. The centre was responsive to patients needs and had systems in place to maintain the level of service provided. They had a clear understanding of who their population group were and understood their needs including, making appointments long enough to provide thorough investigations and treatment.

The access centre had an efficient appointment system in place to respond to patient's needs. There were vacant appointment slots for the dentists to accommodate urgent or emergency appointments. The patients we spoke with told us they were seen in a timely manner in the event of a dental emergency. Staff told us the appointment system gave them sufficient time to meet the requirements of high need patients. Basic periodontal treatment to help maintain patient's gum health was carried out by a dental therapist.

One of the dentists described to us how intranasal sedation had been introduced into the clinic which had helped some patients to tolerate dental treatment without the need of a full general anaesthetic.

Referrals were prioritised by a triage process involving a referral management system and the senior clinicians. The initial wait for an appointment was below 11 weeks. Once the patient is under treatment the 4-week book (future appointments within 4 weeks) meant the rest of the treatment was completed quite quickly. The Senior Dental Nurse told us this was important as it meant confidence built-up with patients would not be lost before the treatment was completed.

Tackling inequity and promoting equality

The special care dentistry service is commissioned to specifically provide access to dental services for vulnerable adults and children. In order to improve the oral health of this vulnerable group of patients we observed plenty of time was allowed for patient appointments.

The Taunton Dental Access Centre had the support of the Oral Health promotion team based at the Burnham-on-Sea satellite clinic and we were told all local schools were regularly visited to apply fluoride varnish to children's teeth. (Fluoride is one method of preventing dental decay). We were told all children regularly received fluoride toothpaste and a toothbrush use of which has been shown to reduce dental decay.

Patients unable to access the centre for dental treatment were visited in their own homes, care homes or nursing homes. We were told due to the number of patients waiting for treatment in this way the number of sessions had been increased to two a week.

All reasonable efforts and adjustments were made to enable patients to receive their care or treatment. Patients reported they had access to and received information in the manner that best suited them and they understood. We saw evidence of reasonable effort and action to remove barriers where patients found it difficult to access or use services. Translators were available via the telephone or in person.

All the facilities of the Dental Access Centre were on the ground floor and accessible to wheelchair-users and those with impaired mobility. Toys, books and colouring sheets were available for children. There was not a hearing loop system but staff who could use sign language were available. Information was available in large print but not in braille.

There is a homeless centre locally and patients from there attend quite frequently. Limited parking was available at the back of the centre with further parking spaces locally and a disabled parking space to the rear of the practice. We were told the centre had access to a translation service either by telephone or in person.

Access to the service

The access centre was open Monday to Friday 8:30am to 5.00pm and was closed between 12.30pm and 1.30pm. The access centre was closed on Saturdays and Sundays. Information regarding the opening hours was available in the premises. The centre answer phone message provided information about opening hours as well as how to access out of hours treatment. Some emergency appointments were kept free each day so the centre could respond to patients in pain. Patients unable to access the centre were visited in their own homes, care homes or nursing homes.

Are services responsive to people's needs?

(for example, to feedback?)

The service is run from a building which has many different clinics. The signage indicating this is the Dental Access Centre was inadequate and made it difficult to find the entrance.

We were told and observed patients had timely access to urgent treatment if required which would usually be on the same day. All patients we spoke with were very satisfied with the appointments system and comments received showed patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Concerns & complaints

The practice had a complaint policy and procedure in place for handling complaints which provided staff with relevant guidance. Complaints were logged onto the Trust database and forwarded to the Head Quarters (HQ) support team. Complaint letters from patients were uploaded to the database in order to ensure they were kept secure. The access centre manager was supported by the complaints department who were able to advise the best way forward and the correct process to follow.

The Senior Dental Nurse told us about two complaints from recent months. One involved a problem with communication where a patient was expecting to have a filling and actually had a tooth extracted. The patient record showed the extraction was correct. The patient was given an apology with which they were happy. The other complaint was a human error in which an account was sent to the wrong patient. Again an apology was written.

We saw five compliments books (one in each surgery and two at reception) that were full of appreciative comments about staff and the service from patients and carers. In 2015 so far there has been a total of 146 comments. Friends and Family test feedback was also available and demonstrated patients were very satisfied with the service received.

Information for patients about how to raise a concern or complaint was available in the waiting room. The access centre manager explained that most complaints were dealt with swiftly and in a timely manner locally thus avoiding the need to escalate to a formal written complaint. Patients we spoke with told us they were confident in raising a concern and would speak to the centre manager.

We noted it was the centre policy to offer an apology when things went wrong. We were told of examples of how the staff had exercised their duty of candour with an apology that had been offered following a patient's complaint and a record made in their notes.

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 with externally such as the Care Quality Commission (CQC).

Are services well-led?

Our findings

Governance arrangements

The Senior Dental Nurse told us clinic meetings were held on a monthly basis. The senior clinicians and senior dental nurses also met together bi-monthly and the senior dental nurses met monthly. In addition the infection control leads; the radiography nurses and the domiciliary staff from the clinics within the Trust met regularly.

We were told there was a best practice group of senior clinicians and information from them is cascaded down to all appropriate staff. Policies and procedures are available to view on the public website.

Leadership, openness and transparency

Individual clinicians are identified as lead professional for Safeguarding, Infection Control, Medical Emergencies, Sedation and Domiciliary care.

Staff we talked with generally felt well-supported in their jobs, both locally at the access centre and by the Trust. There was one whistleblowing incident regarding poor clinical performance recently which one member of staff felt had not been handled well. In particular the member of staff felt the situation had not been acted upon early enough and feedback had not been forthcoming about why the situation had not been resolved.

The Trust did not always implement nationally recognised guidance in respect of emergency treatment for domiciliary visits. 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 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.

Learning and improvement

Staff told us how they were able to readily access training and managers supported them in this process. We saw evidence staff were working towards completing the required number of continuing professional development hours to maintain their professional development in line with requirements set by the General Dental Council.

The access centre had a programme of clinical audit and risk assessments in place. These included audits for infection control, clinical record keeping and x-ray quality which showed a generally high standard of work.

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

The Senior Dental Nurse told us the last general patient satisfaction survey had shown only two complaints – one the lack of a sign for the Dental Access Centre and the other concerning the car park.