Gloucestershire Care Services NHS Trust

R1J

Community dental services

Quality Report

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Date of inspection visit: 18 - 21 August 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1JX3	Southgate Moorings		
R1JAT	The Dental Clinic – Redwood House		
R1JX7	The Dental Clinic – St Pauls Medical Centre		
R1J50	The Dental Clinic – Springbank		
R1JX5	The Dental Clinic - Bourton on the Water		
R1J07	Vale Hospital		
R1J56	The Dental Clinic - Lydney		

This report describes our judgement of the quality of care provided within this core service by Gloucester Care Services NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Gloucester Care Services NHS Trust and these are brought together to inform our overall judgement of Gloucester Care Services NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Summary of findings

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Overall summary

Overall we judged the dental services to be good. Patients were protected from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place.

Dental services were effective and focussed on the needs of patients and their oral health care. We observed good examples of effective collaborative working practises within the service. The service was able to meet the needs of the patients who visited the clinics for care and treatment because of the flexible attitude of all members of staff.

The patients we spoke with, their relatives or carers, said they had positive experiences of their care. We saw good examples of care being provided with compassion and of effective interactions between staff and patients. We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed how dedicated they were in what they did.

The service was well-led. Organisational, governance and risk management structures were in place. The operational management team of the service were visible and the culture was seen as open and transparent. Staff were aware of the vision and way forward for the organisation and said they felt well supported and that they could raise any concerns.

There was effective multidisciplinary team working and links between the different clinics to refer people onward for care. Individual assessments were carried out and specialist equipment was available to meet the needs of patients who had reduced mobility or for those patients who were obese. However. the service was not always responsive to people's needs, with some waiting times exceeding six months.

We found inconsistencies in decontamination procedures across the service. These had not all been identified through routine audit.

Summary of findings

Background to the service

Gloucester Care Services NHS Trust provides community dental services for all age groups who require a specialised approach to dental care and are unable to receive this in a General Dental Practice. They also provide general dental services from Springbank Clinic, Cheltenham. The Gloucester Clinic, Southgate Moorings, Gloucester and St Paul's Medical Centre, Cheltenham provide access for urgent dental advice and care for those people in Gloucestershire who are not registered with a General Dental Practitioner and who are experiencing dental pain or dental trauma during core hours.

The Community Dental Service provides NHS Dental care for a wide range of patients who find it difficult to access general dental services from traditional dental practices.

Patients are referred in to the service with a variety of needs including but not limited to:-

- physical and or learning disabilities
- acute dental phobia
- children with high dental need and behaviour management difficulties
- people with dementia
- domiciliary care for those patients who are unable to leave their home
- head and neck cancers
- substance misuse
- HIV Aids
- complex medical conditions
- the homeless and other vulnerable groups

The Gloucester Clinic, Southgate Moorings, Gloucester provides access for urgent dental advice and care for those people in Gloucestershire who are not registered with a General Dental Practitioner and are experiencing dental pain or dental trauma during core hours.

- The Gloucester Dental Clinic operates 7 days a week, providing an Emergency Out of Hours advice and treatment service at weekends and Bank Holidays
- Emergency Out of Hours Service is available for all residents and visitors to the county of Gloucestershire
- People accessing this service are triaged by qualified and experienced Dental Nurses who follow the Scottish Dental Clinical Effectiveness Programme, Emergency Dental Care Guidance.
- People triaged are offered advice on managing their dental problem and if required an appointment will be arranged for conditions requiring emergency care.
- Advice is also offered to those who are not registered with a General Dental Practitioner on where to access NHS Dentists in Gloucestershire for future care

Routine Dental Care is provided at Springbank Dental Clinic, Cheltenham

- The service was commissioned originally as part of the SureStart initiative.
- Provides routine NHS dentistry to residents of GL51 postcode area.

The service provides oral health care and dental treatment for children and adults that have an impairment, disability and/or complex medical condition. People who come into this category are those with a physical, sensory, learning, mental, medical, emotional or social impairment or disability, including those who are housebound. The service also provides urgent 'in hours' and 'out of hours' dental services for patients who are unable to obtain routine care from local NHS 'high street' dental practices' and general dental services for a specific post code area.

An inhalation sedation service is provided in selected clinics where treatment under a local anaesthetic alone is not feasible and conscious sedation is required.

General anaesthetic (GA) services are provided for children in pain where extractions under a local anaesthetic would not be feasible or appropriate such as in the very young, the extremely nervous, children with special needs or those requiring several extractions. This service is also for adults with complex special needs where examinations, radiographs, restorations and extractions can be provided. GA procedures are delivered at:

- Gloucester Royal Hospital day stay units

There are 9 Community Dental Clinics situated across the county of Gloucestershire

During our inspection we visited seven locations which provided a special care dental service:

Summary of findings

- Southgate Moorings – special care dental treatment for all age groups and urgent in-hours and out of hours care.
- St Paul's Medical Centre – special care dental treatment for all age groups and urgent in-hours care.
- George Moore Community Clinic – special care dental treatment for all age groups
- Redwood House Stroud- special care dental treatment for all age groups.
- The Vale Community Hospital - special care dental treatment for all age groups.
- Lydney Health Centre-special care dental treatment for all ages
- Springbank Resource Centre- general dental services for any patient in the GL51 post code area.

Our inspection team

Chair: Dorain Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

Our inspection team was led by: a CQC Inspector and was supported by a Dentist Specialist Advisor.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 18 – 21 August 2015. We talked with people who use services. We observed how people were being cared for and talked with staff, carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During our inspection of Gloucester Care Services NHS Trust Dental services we spoke with patients at four of the locations we visited; we also reviewed the comments made through the Friends and Families Test.

We spoke with patients attending for both urgent dental care and for appointments with the community dental service. All the patients we spoke with were positive about the care and treatment they received.

They told us that all staff were very professional and did everything possible to make them feel at ease. Patients told us they had been referred to the service as they were very anxious about having dental treatment. One patient told us; "I was very impressed they made me feel relaxed and made me feel in charge."

We spoke with three parents who were attending the service with their child, they said that all the staff spoke with their child in an age appropriate way and made

Summary of findings

them feel involved in all aspects of their care and treatment. One said; “They involved my daughter, the dentist and nurse were very calm, they were both fantastic”.

A patient waiting to see a dentist for emergency care told us how they had accessed the service and gone through the triage system: “I called the clinic at St Paul’s and was told the triage nurse would call me back which she did within an hour. They asked sensible questions and I was given an immediate appointment.

The NHS choices website held mixed reviews with all the negative comments referring to the urgent care service. These comments were mainly around the waiting time for the telephone to be answered and the inability to get an appointment as their dental problem did not fall into the scope of the urgent care service. The service had responded to the negative comments and had introduced further telephone lines which were answered by the triage team rather than directed through a receptionist.

Good practice

- The service had responded to the complex needs of their patients and had invested in a number of items of specialist equipment, such as a wheel chair tipper, a number of bariatric chairs and specialist x-ray equipment. This enabled staff to provide treatment in a safe effective and comfortable way for patients.
- As part of the dementia link work the service had produced a training video which consisted of two parts, one demonstrating a poor approach to oral care and the other showing best practice and how this would ensure a good outcome for the patient. The video was used to initiate discussion at training sessions for community and care home staff.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure inconsistencies in decontamination procedures between areas are identified and procedures and protocols put in place to address them.
- Review waiting lists to ensure people did not have excessive waiting times for treatment.

Gloucestershire Care Services NHS Trust

Community dental services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm or prevent harm from occurring. Staffing levels were safe in the clinics with a good staff skill mix across the whole service. We observed good infection prevention and control practices. The available equipment for the decontamination of instruments met best practice in a number of the sites we visited. However the provider should make improvements to ensure that guidance available for staff was consistent throughout the service.

Detailed findings

Safety performance

- As a result of a previous clinical incident the service had introduced a more robust system and process to be followed by clinicians prior to patients undergoing dental extractions. A protocol had been written which included a check list of steps to be taken by before during and after a tooth extraction. The protocol had been written in consultation with all clinicians to reaffirm the process they followed.
- At all the sites we visited clinical records were kept securely and could be located promptly when needed, confidential information was properly protected. Patient records were a mixture of computerised and paper copy records. Computerised records were secured by password access only. At Southgate Moorings, digital orthopantomograph (OPG) images were taken and uploaded onto patients' clinical records. (An OPG is a panoramic scanning dental X-ray of the upper and lower jaw). Other written information such as medical histories, consent forms, NHS administrative forms and referral correspondence were collated in individual patient files and archived in locked and secured cabinets which were not accessible to the general public in accordance with data protection regulations.

Incident reporting, learning and improvement

- We found the dental services protected patients from abuse and avoidable harm as staff were confident about reporting serious incidents and providing information to their line manager, dental service manager or one of the clinical directors if they suspected poor practice which could harm a patient. Staff told us incidents, accidents or near misses were reported on the incident reporting system (Datix) which enabled the service to collate and report on any trends.

Good

Are services safe?

- We found mechanisms were in place to monitor and report safety incidents, including "never events". Staff told us incidents, accidents or near misses were reported on the organisations risk management system. Staff we spoke with described the system of incident reporting, the system appeared simple and straight forward to use. There were procedures in place to ensure that any incident occurring away from the dental clinic, such as during a domiciliary visit was recorded on the organisation's electronic system as soon as possible after the event.
- The outcomes of incidents were reported upwards through the Trust's reporting system and downwards to departmental staff through the regular team meeting structures. This mechanism ensured that all members of the staff team were able to learn lessons and implement appropriate remedial measures wherever possible to prevent harm to patients and staff. We saw staff meeting minutes which demonstrated such learning had taken place. For example, we saw as a result of a previous clinical incident, that the department had introduced a more robust system and process to be followed by clinicians prior to patients undergoing dental extractions. This system helped to avoid any future "never events" such as wrong tooth extraction. There was a consistent approach to sharing learning from incidents. All significant events were discussed at clinical governance committee meetings. There was a programme of staff meetings; each meeting took place at three venues, with the same agenda. This ensured all staff had the opportunity to attend and consistent information about learning from events was shared.
- Incidents or concerns were acted on in a timely way. For example a dentist had raised concerns about the X-ray equipment in the surgery they used. This concern was minuted at a staff meeting and on the day of our inspection the X-ray unit was being tested by a representative from medical physics and a service appointment had been booked.

Safeguarding

- The staff we spoke with were knowledgeable about safeguarding issues in relation to the community they served. The service had a safeguarding lead so that staff who encountered any safeguarding concerns could discuss with a more experienced colleague before making a referral to appropriate agency. All of the staff we spoke to were aware of the safeguarding concerns that could impact upon the delivery of dental care. This included children who presented with high levels of dental decay which could indicate that a child is suffering from neglect. Staff we spoke with at Lydney clinic described the very close working relationship they had with the school nursing staff and other agencies within the Trust. This ensured that any safeguarding issues were dealt with in a timely manner.
- All staff we spoke with were aware of the safeguarding policy and had said they had received training with regards to safeguarding vulnerable adults and children. Staff training records showed that 57 out of 69 staff had received training in the subject in the previous two years with the remaining 12 having their training over three years ago.
- The local authority safeguarding team invited staff to attend any child protection meeting if the issues concerned one of their patients. Staff routinely attended these meetings or provided any relevant information. Staff told us if they had any safeguarding concerns they were able to raise them with the local authority team to ascertain if they were subject to a child safeguarding plan.
- The service worked closely with the school nursing service, health visiting, learning disability teams and dementia services. Patients who may be vulnerable to safeguarding issues were protected in a timely manner and are prevented from coming to harm from various forms of abuse. One of the dentists also described the information sharing with a patient's GP and social services in relation to child safeguarding to ensure treatment appointments were attended.

Medicines

- Medicines were stored safely for the protection of patients. A comprehensive recording system was available for the prescribing and recording of these medicines. The records were well completed and provided an account of medicines prescribed. All blank prescriptions were tracked through the service.
- Medicines for emergency use were all in date and stored securely. Emergency oxygen was stored in a central location known to all staff. A check list monitoring the expiry dates of the emergency medicines was present in each storage cabinet at each location we visited and

was signed by the responsible dental nurse. This ensured that the risk to patients during dental procedures was reduced and patients were treated in a safe and secure way.

- Out of date medicines, such as local anaesthetics, were disposed of securely in appropriately labelled containers.
- Emergency equipment such as an Automated External Defibrillator, emergency medicines and oxygen was available in line with the Resuscitation UK and British National Formulary (BNF) guidelines.

Environment and equipment

- Surgeries used for patient treatment contained dental equipment that was clean and well maintained, and there were sufficient supplies of equipment in all locations visited.
- Equipment used during inhalation sedation was maintained in accordance with the manufacturer's instructions. There were records of the maintenance checks and the individual checks carried out before each patient was recorded in the patient's dental care record.
- Risk assessments in relation to the environment whilst providing domiciliary care had not been formally completed. The service had a domiciliary care protocol and a trust wide protocol in relation to domiciliary care. However dental care records showed the treatment needs of the patient had been considered and whether they could be safely and effectively provided in the patient's home.
- At each site we visited we were shown a well maintained radiation protection file. This contained all the necessary documentation pertaining to the maintenance of the X-ray equipment. It also included critical examination packs for each X-ray set along with the annual maintenance logs. A copy of the local rules was displayed with each X-ray set. The clinical records we saw showed that when dental X-rays were prescribed they were justified, reported on and quality assured every time. This ensured that the service was acting in accordance with national radiological guidelines. The measures described also ensured that patients and staff were protected from unnecessary exposure to radiation.

Quality of records

- At all the sites we visited clinical records were kept securely and could be located promptly when needed, confidential information was properly protected. At each of our inspection visits we looked at a sample of dental records. The electronic records and paper copy records were well-maintained and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and estimates and treatment records. Clinical records viewed were clear, concise and accurate and provided a detailed account of the treatment patients received. Patient safety and safeguarding alerts were also thoroughly recorded. For example allergies and reactions to medicines.
- The service had carried out an audit of record keeping in 2014. This had looked at a selection of 499 patient records. Although the audit found that the records were of a high standard, with appropriate information recorded in 92 -100% of cases, there was an area for improvement. The record of allergies had not been completed in 12% of the records. There was an action plan to increase this with an aim of 100% when the next audit was scheduled for February 2016.

Cleanliness, infection control and hygiene

- The service used a system of local decontamination at all the sites we visited though was in the process of moving over to a '3 hub' approach for local decontamination. It was envisaged that the service would employ decontamination technicians whose specific role would be that of decontamination of dental instruments. With this proposed system the smaller clinics would have contaminated instruments transported to one of the 'hub' sites for the process of decontamination and cleaning.
- The system of central decontamination was in place at one of the 'hub' sites, Redwood House. Other sites including Southgate Moorings were meeting HTM 01 05 (guidelines for decontamination and infection control in primary dental care) best practice requirements for infection control. Those sites not at best practice were meeting essential quality standard and were unable to meet best practice due to the constraints of the building. Staff at these centres showed us and demonstrated the arrangements for infection control and decontamination procedures. They were able to

demonstrate and explain in detail the procedures for the cleaning of dental equipment and for the transfer, processing and storage of instruments to and through designated on-site decontamination rooms.

- Staff we spoke with were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:
- Hand washing facilities and alcohol hand gel available throughout the clinic area
- Staff followed hand hygiene and 'bare below the elbow' guidance
- Staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care and treatment.
- Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
- Cleaning schedules in place and displayed for each treatment room. These were complete and were signed by the responsible dental nurse.
- Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- We observed the daily, weekly and quarterly test sheets for the autoclaves and washer disinfectors along with the maintenance schedules at each location where local decontamination was carried out. These were signed by either the responsible dental nurse or the external company carrying out the quarterly validation checks
- The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. The use of safer sharps and the treatment of sharps waste was in accordance with current guidelines. Sharps injury protocols were on display in each clinical area and understood by the staff we spoke to. We observed that sharps containers were well maintained and correctly labelled. This ensured that staff, patients and other members of the public were protected from the risk of sharps injuries. The same system of safer sharps was in place at domiciliary visits and staff carried sharps containers which could be sealed for transportation.
- However we did find some inconsistencies in the decontamination process. For example the types and frequency of autoclave tests and the recording and storage of autoclave printouts. Some procedures varied from site to site and staff understanding of the procedures was not always clear. Although these inconsistencies did not present patient safety concerns, the processes did not always follow the guidance as set out in HTM 01 05. For example in relation to the temperature of the water used to submerge instruments. Staff did not manually clean instruments but some staff had not appreciated that soaking instruments should follow the same temperature guidelines.
- We discussed or findings in relation to infection control with the staff and management team. Arrangements were made for the three senior nurses to audit the service as a whole and some changes were made immediately such as re-siting the X-ray developer away from all decontamination processes.

Mandatory training

- Staff across the service told us there was good access to mandatory training study days and profession specific training. The profession specific training, as long as it was relevant to the individual's role, would be allocated as a result of the annual appraisal process. The range of mandatory training included safeguarding, infection prevention and control, dealing with medical emergencies in the dental surgery and health and safety. The staff we spoke with all reported that they had received mandatory training in all of these areas.
- A central log of training was maintained by the service to ensure that organisational and professional requirements were satisfied. This was checked regularly and a summary prepared for discussion at each staff member's appraisal. Staff training records showed that all staff were up to date with the subjects stipulated by the service as mandatory.

Assessing and responding to patient risk

- Throughout our inspection we found close attention paid to assessing patient risk and ensuring that patients did not come to harm during dental treatment. This included maintaining current medical, social and dental histories and maintaining accurate, contemporaneous and complete dental treatment records. The service had introduced a number of specialised dental chairs for patients who presented with special needs. This included specialised 'wheel chair tippers' which avoided the need for wheel chair user patients to transfer to a conventional dental chair and prevent any unnecessary

harm which could occur to patients and staff alike during patient transfer. This was also the case with the availability of a special bariatric chair for severely obese patients requiring dental treatment.

- Risk assessments were undertaken when assessing the suitability of a patient for care in a domiciliary setting. Assessment included details of the patient's medical condition, mobility and whether assistance from a carer was required. Details of any clinical intervention was recorded and where possible the records were transferred to the dental computer software system as soon as possible following the visit. This enabled follow up care to be provided by another clinician in the event of staff annual leave or sickness.
- We discussed with several dentists during our visit how patients were discharged from the service after GA and conscious sedation. We were assured that patients were discharged in an appropriate, safe and timely manner. During the discharge process the nurses made sure the patient or responsible adult had a set of written post-operative instructions and understood them fully. They were also given contact details if they required urgent advice and or treatment. This was corroborated by looking at patient records where sedation had been given.
- To prevent wrong site surgery, the service adopted a number of fail-safe processes to prevent such incidents. All patients requiring dental treatment under General Anaesthesia (GA) had their referrals overseen by a senior clinician. No patient was allowed to go to hospital theatre unless the treatment plans had been authorised by these senior clinicians. Staff completed World Health Organisation checklists for each patient who had treatment under general anaesthetic. These checklists were in place to ensure all possible safety checks were completed and agreed by all staff before surgery started.

Staffing levels and caseload

- Through careful management of the staff rotas, access to all of the clinics across the area was maintained for patient care and treatment. Appointment slots were allocated for both patient assessment and treatment sessions and staff we spoke with felt that they had adequate time to carry out the clinical care of patients. There was sufficient clinical freedom within the service to adjust time slots to take into account the complexities of each patient's medical, physical, psychological and social needs.
- Staff numbers were planned to deal with current demand on the service. Staffing levels were constantly reviewed according to need. We spoke with staff who told us they changed locations according to need or planned staff absence.
- Each clinician was supported by a qualified dental nurse at all times. There was sufficient capacity to have a dental nurse working in the decontamination room which freed up staff for duties in the surgery.
- The actual number of staff planned for were on duty at the time of our inspection. However staff told us that as a number of them were part time they could cover for staff sickness at short notice if required. The dental nurse working in decontamination could be called upon to work in the treatment room if required.

Managing anticipated risks

- All clinical staff undertook yearly training in 'Medical Emergencies in the Dental Practice' and basic cardio-pulmonary resuscitation (CPR) appropriate to the clinical grade of the member staff. For example staff involved in providing sedation or general anaesthetic services undertook training in intermediate life support techniques. This was in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015. There was easily accessible equipment and medicines to deal with a medical emergency should it arise.
- The service had a named Radiation Protection Adviser and a number of Radiation Protection Supervisors spread across the county who are appointed to provide advice and assurance that the service is complying with legal obligations under IRR 99 and IRMER 2000 radiation regulations. This included the periodic examination and testing of all radiation equipment, the risk assessment, contingency plans, staff training and the quality assurance programme. The services' named Radiation Protection Supervisor ensured compliance with Ionising Radiation Regulations 99 and IRMER 2000 regulations was maintained.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Services were effective, evidence based and focussed on the needs of patients with collaborative team working evident. Staff received professional development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC), had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration. Staff were aware of best practice guidance and professional updates to clinical care and treatment.

Preventive care across the service was delivered using the Department of Health's 'Delivering Better Oral Health Toolkit 2014'. Dental nurses at some of the locations held dedicated oral health clinics to provide one to one advice and oral health instruction.

There were clear referral protocols for referral into the community dental service. Patients requiring urgent care were triaged by a trained and experienced dental nurse. All patients were triaged to assess their needs of either treatment or advice. Staff used the Scottish Dental Clinical Effectiveness Programme, for emergency dental carer guidance.

Detailed findings

Evidence based care and treatment

- The service had a number of clinical leads who ensured best practice guidelines were implemented and maintained, these included general anaesthesia and sedation, health and safety, clinical audit and clinical governance. Guidelines and protocols were available to staff in hard copy at each location, on the electronic shared drive and were regularly discussed at staff meetings.
- Dental general anaesthesia (GA) and conscious sedation was delivered according to the standards set out by the dental faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care 2015. This care was delivered to best practice standards as specified in the new guidelines.
- Domiciliary dental care was provided using the standards set out in the Guidelines for Domiciliary Care by the British Society for Disability and Oral Health (BSDOH). A senior clinician and senior dental nurse we spoke with explained the patient journey involving an episode of domiciliary care.
- The service worked to the principles of National Institute for Health and Care excellence in relation to recall intervals for patients. This was a risk based approach to the care and treatment of patients who, by their complex needs, were not suitable for referral back to the care of their general dental practitioner.

Pain Relief

- Patients' need for pain relief was constantly assessed and discussed with each patient for each item of treatment. Local anaesthetic was used for patients if the clinician felt it would be necessary for the level of treatment or if the patient requested it.
- Pain relief in the form of analgesia for dental pain was advised or prescribed, as appropriate, to patients attending for urgent care.
- Local anaesthetic was administered according to the treatment required and the setting where treatment took place. There were comprehensive standard operating procedures to support the use of inhalation sedation for anxious patients. These followed available essential standards for practice guidelines. The GDC requires registrants to receive appropriate supervised theoretical, practical and clinical training and be assessed prior to using sedation. We saw training records for staff with regards to training and observed staff following this guidance in their discussions and interactions with patients. To support the verbal advice the dentists gave following treatment, written advice leaflets were available at all the centres, which gave advice on pain relief for when the patient returned home.

Patient outcomes

- Preventive care across the service was delivered using the Department of Health's 'Delivering Better Oral

Health Toolkit 2013'. Dental nurses at some of the locations held dedicated oral health clinics with an appointment system where patients received one to one advice and oral health instruction.

- The service had a number of dementia and learning disability champions who provided targeted support to staff in the community including care homes, supported living and health care assistants. This enabled those staff to act as oral health champions in each of their community settings, promoting good oral health self-care throughout their client groups.
- The service had a clinical audit lead. This was a senior clinician who coordinated all clinical audit activity throughout the service. We observed a well ordered and maintained clinical audit file. Current audit projects included clinical record keeping, infection prevention control and dental radiography, antimicrobial prescribing, consent and treatment planning. The infection control audit had been conducted for each site but had failed to recognise the inconsistencies across the service.
- We saw minutes of clinician "peer review" meetings. These meetings took place every 2-3 months. Dentists were able to bring to the meetings interesting clinical scenarios for group discussion. These discussions allowed dentists to offer advice to the presenting clinician about alternative treatment plans and approaches to treatment in a non-threatening and judgemental environment. The dentist we spoke with explained how much the staff valued this method of peer review and the valuable learning that resulted from looking at the same clinical scenario from a variety of viewpoints.

Competent staff

- All dental nurses employed by the service were registered by the General Dental Council and had a qualification in dental nursing. Many dental nurses had taken post qualification study. Fifty eight per cent of nurses had a post graduate qualification, including sedation, dental radiography and oral health education.
- Five nurses were trained to assist during treatment under general anaesthetic in the hospital setting and a further five were undergoing training. There were seven trained dementia link workers throughout the county and five learning disabilities champions within the nursing team. The Clinical Directors encouraged dentists and dental therapists within the service to carry out additional training to provide services to an ever increasing complexity of patient. All staff had the opportunity to take further courses to enhance the patient experience dependant on the outcome of their appraisal and subsequent personal development plan. Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Wherever possible the Trust supported this philosophy by providing partial funding for studying or attendance at courses and providing appropriate levels of study leave.
- All staff could demonstrate they were up to date with their continuing professional development which was a requirement of their on-going registration. Staff knew where in their three year cycle they were and the hours of verifiable and non-verifiable training they had taken part in.

Multi-disciplinary working and coordinated care pathways

- Patients in need of GA and sedation care had their care prescribed using an approved care pathway approach. Patients entered a recognised pathway of: Cognitive Behavioural Therapy, Tender Loving Care (TLC), TLC and inhalation sedation and finally GA dependent upon each individual patient's medical, social or clinical need.
- There was evidence of multidisciplinary working as appropriate. For example patients often presented with complex medical conditions requiring consultation with their general practitioner and or Consultant Physician or Surgeon.
- The service maintained close working relationships with the school nursing service, health visiting, learning disability teams and dementia services to ensure that vulnerable groups requiring dental care could readily access treatment and care to meet their needs.

Referral, transfer, discharge and transition

- There was a clinician led system for handling referrals into the community dental service. A senior clinician in the service providing a triage system to assess the appropriateness of the referrals and to arrange the most appropriate clinic for the patient to visit. At this point,

information gaps were identified which enabled staff to arrange for further dental radiographs, blood tests, or advice from the patient's GP or referring dentist, so that the patient was then seen in the right place at the right time. As a result, the number of inappropriate referrals had been reduced.

- The service maintained a list of patients within the service for continuing care. This ensured that patients with learning disabilities and long term medical conditions which could compromise dental care and may not be able to access dental care in a 'high street' setting could access ongoing dental care.
- Patients who received single courses of treatment for sedation services or general anaesthesia are discharged back to their referring general dental practitioner with a comprehensive discharge letter detailing the treatment carried out by the service.
- Patients attending the urgent in hours and out of hours services whom may have special needs and did not have access to regular care, were offered continuing care within the community service.
- Those patients who attended the service for urgent care received a single item of treatment to ensure they were free of pain. They were then referred to their general dental practitioner or given details of dentists in the area providing NHS treatment.

Access to Information

- Patient treatment records were a mixture of paper copies and electronic records. Electronic patient records could be accessed from any of the dental clinics operated by Gloucester Care Services Dental Service. Paper records were taken to patients' own homes when domiciliary care was provided. All records were transferred to the electronic system as soon as possible after the clinicians returned to the clinic.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed a robust system for obtaining consent was in place for patients undergoing General Anaesthesia, inhalation sedation and routine dental treatment.
- The consent documentation used in each case consisted of: the referral letter from the general dental practitioner or other health care professional, the clinical assessment including a complete written medical, medicines and social history and bespoke written consent forms. Pre-operative and post-operative check lists and patient information leaflets detailing pre-operative and post-operative instructions for the patient to follow completed the consent process. We observed a selection of clinical records which demonstrated that the process was completed in full.
- Staff had a good understanding of consent and applied this knowledge when delivering care to patients. Staff we spoke with had received training on consent and had the appropriate skills and knowledge to seek consent from patients or their representatives. We observed positive interactions between staff, patients and/or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered.
- Where adults or children lacked the capacity to make their own decisions, staff sought consent from their family members, or representatives if they were legally entitled to give consent. Where this was not possible, staff made decisions about care and treatment in the best interest of the patient and involved the patient's representatives and other healthcare professionals. Staff told us of the procedures in place and we saw that decisions were recorded in detail in the patient record. Multi-disciplinary team meetings to discuss best interest decisions were not routinely held but there was evidence recorded in patient care records that other health and social care professionals were consulted appropriately.
- All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

Patients told us they had positive experiences of care at each of the clinics we inspected. Patients, families and carers felt well supported and involved with their treatment plans and staff displayed compassion, kindness and respect at all times.

We found staff to be hard working, caring and committed to the work they did. Staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to patients and their representatives and the values and beliefs of the organisation they worked for.

Staff as part of Gloucester care services took part in 'my name is'. This was introduced in the trust to ensure all patients knew who they were meeting.

Detailed findings

Compassionate care

- Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care. Patients, their relatives and carers were all positive about the care and treatment they had received from the dental team.
- We observed several patients being treated in a domiciliary setting as well as a clinic setting. In both situations we saw extremely kind, gentle and compassionate care being given to patients, with the team work between the dental nurses and the dentists ensuring the delivery of a very good patient experience.
- We observed all staff treating patients with dignity and respect. Staff were observed taking extra time with patients who didn't have full capacity to fully understand the advice being given. We observed at one clinic how the dentist and dental nurse built and maintained a respectful and trusting relationship with a patient with special needs and their carer. The dentist sought the views of the patient regarding the proposed treatment even though the patient did not have the capacity to make decisions. The patient was given explanations about their dental treatment in a language they could understand. They were treated with respect and dignity at all times.
- Many patients were well known to surgery staff. Reception staff described how they were able to alert dentists or dental nurses if they had any concerns about a patient. For example if a patient appeared to be acting out of character or if they looked unwell which could indicate an underlying reason.
- During our observations in the waiting rooms of each dental clinic we did not hear any personal or sensitive information being discussed. We noted that when people required support with forms or to understand information this was done in the treatment rooms.
- The service used a number of methods to capture patient feedback and determine patient satisfaction levels. These included information from the Friends and family test, 'Your experience counts', comments books and regular monitoring of the NHS choices feedback. Feedback was routinely analysed and action plans put in place to address any concerns.
- Feedback from patients about the standard of care and compassion they received was positive. However there were a number of negative comments on NHS choices relating to the urgent care service. Negative comments were around the waiting times for telephones to be answered and the frustrations of being unable to access an appointment as their needs did not match the criteria for treatment by the service. In response to the concerns relating to telephoning the service a change to the telephone system was to take place on 1 September 2015. Two dedicated telephone lines for urgent care were to be operational these would be answered by trained triage dental nurses.

Understanding and involvement of patients and those close to them

Good

Are services caring?

- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found that planned care was consistent with best practice as set down by national guidelines.
- Observation of practice and review of patient records evidenced that staff were assessing the patients' capacity to be able to give valid consent using the Mental Capacity Act (MCA). We found that relatives and/or the patient's representative were involved in discussions around the care and treatment where it was appropriate.
- We spoke with a number of parents attending with their child for treatment. They all commented positively about the way their child was communicated with. They told us that staff spoke with their child in an age appropriate way and involved them in discussions and explanations in a way they could understand.

Emotional support

- Staff were clear on the importance of emotional support needed when delivering care. We observed the dedication of staff, at all levels, in providing high quality care for patients and putting the patients' interests first at all times. Direct observation of treatment sessions showed every patient encounter was carried out in a very kind and caring way. We observed positive interactions between staff and patients, where staff knew the patients very well and had built up a good rapport. We observed exceptionally kind and caring support being given to patients who were very fearful of the dentist. The staff all adopted a holistic approach to care concentrating fundamentally on the patients social, physical and medical needs first, rather than seeing patients as a collection of signs and symptoms which required a mechanistic solution to their dental problems.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

The service was not always responsive to people's needs. People from all communities could access treatment if they met the service's criteria, however in some areas waiting times exceeded six months. In order to reduce this, one clinic had closed its waiting list. There was effective multidisciplinary team working and links between the different clinics to refer people onward for care that met their needs. Individual assessments were carried out and specialist equipment was available to meet the needs of patients who had reduced mobility or for those patients who were obese

Detailed findings

Planning and delivering services which meet people's needs

- All patients attending the community dental service were given a choice as to where they would like to be treated; the aim of giving patients this choice was to keep waiting times for their assessment and treatment as short as practically possible.
- A range of literature was available for patients, relatives and/or their representatives and provided information in regards to their involvement in care delivery from the time of admission through to discharge from the service. This included: Pre-treatment instructions, key contacts information and follow-up advice for when the patient left the clinic. Information was sent to patients before their first assessment appointment and written information was handed to the patient at the appropriate stage of their care pathway. Some patient literature was in an easy read format, such as comment cards and Gloucester Care Services information leaflets, which included dental services, were available in braille, audio format, large print and other languages on request. Staff had access to translation services should they be needed to support any patient whose first language was not English.
- Children attending special schools are offered a dental examination at school on an annual basis
- Teams of trained and calibrated dentists and nurses carry out the annual National Oral Health Epidemiological Surveys required by the Department of Health to assess treatment and oral health needs of certain sections of the population.

Equality and Diversity

- We found that people had individual assessments which covered a number of areas including communication needs, physical needs such as specialist equipment they might need and any other difficulties they may have accessing the service. This enabled the service to support people by, for example, arranging an interpreter, specialist equipment or appointment times to suit patients' needs wherever possible.
- Interpreter services were available and staff were confident in accessing this service if it was necessary.
- Specialist equipment was available to meet the needs of patients who had reduced mobility or for those patients who were obese.
- All the waiting rooms and treatment rooms we saw during our inspection were suitable for the patient population. For example waiting rooms were large enough for patients who used wheelchairs and provided a relaxed atmosphere for those patients and children who were anxious of dental treatment.

Meeting the needs of people in vulnerable circumstances

- The service provided referral based specialised service as well as continuing care to a targeted group of patients with special needs due to physical, mental, social and medical impairment. These groups could access services when required to meet their needs and the needs of family and carers. The locations we viewed as part of our inspection were fully accessible for people with a physical disability or who required the use of a wheelchair. Accessibility to the clinics we visited was good and most had car parking that was available on each site or very close by.

Requires improvement

Are services responsive to people's needs?

- The service provided domiciliary care for patients who due to their circumstances were not able to attend one of the dental clinics. This service was available to patients in the area covered by Gloucester Care Services.
- The service had made large investments in equipment to meet the needs of patients. Some of the locations had 'wheel chair tippers' which enabled wheelchair users to receive treatment in the safest most comfortable and effective way. There were a number of bariatric dental chairs to meet the needs of obese patients and also a number of 'leg break' dental chairs which moved from a normal sitting position to a conventional dental chair. These provided easy access for people with reduced mobility and a more acceptable chair for patients with a learning disability. The service had recently acquired a specialist x-ray machine which enabled patients using a wheelchair to have a more comfortable experience whilst being x-rayed as well as an improved x-ray image.

Access to the right care at the right time

- Patients were referred to the community dental service for short-term specialised treatment. A set of acceptance and discharge criteria had been developed so that only the most appropriate patients were seen by the service. On completion of treatment, patients were discharged to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist. Internal referral systems were in place, should the dental service decide to refer a patient on to other external services such as local maxillofacial specialists.
- The service made us aware of the challenges they face with the high volume of referrals received. Limited numbers of staff, recent staff sickness and the pressure of providing emergency care meant special care patients had long waiting times for an initial assessment. There were a total of 1025 patients on a waiting list. Figures showed the wait was in excess of six months in some geographical areas. Some patients referred to the Springbank Clinic had been waiting since October 2014. They had closed the waiting list for that clinic and had also responded by setting up a central point for managing referrals. The aim was to reduce waiting times by checking if a patient could be seen at another clinic which may be convenient for them with a shorter waiting time. These figures formed part on a monthly report presented to the Countywide Quality Board.
- Eighteen week wait targets were met for those patients who had been referred specifically for general anaesthetic. There was flexibility within the service to prioritise those patients especially children who were in pain.
- Protocols were in place to ensure that appointments were prioritised according to risk for those patients contacting the urgent care triage system.
- Patients who did not attend for urgent care appointments were deemed to no longer require the appointment. However patients attending the community dental service were contacted if they missed an appointment to ensure they continued to receive appropriate treatment or support to attend.

Learning from complaints and concerns

- Information about how to complain or raise a concern was readily available and easy to understand. Posters and leaflets were available in waiting rooms; this included an easy read comment card.
- The community dental service element of the service had a low level of complaints. At the sites we visited where there were dedicated reception staff, we observed the clinics had very personable 'front of house' staff who would be able to resolve potential complaints. From speaking to staff the emphasis was on de-escalation and local resolution of problems which may have contributed to the low level of complaints received by the service. Staff we spoke with explained that there were more complaints arising from the out of hours element of the service; however this was more to do with the inherent nature of the service and patients not fully appreciating the limitations of what out of hours services could realistically provide. Comments from NHS choices showed that patients thought that any dental treatment could be accessed through the service. Patients who called the service who did not have an NHS dentist were signposted to NHS choices and the role of the urgent service was explained to them.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

The service was well-led with organisational, governance and risk management structures in place. The local management team were visible and the culture was seen as open and transparent. Staff were aware of the vision for the organisation and felt well supported.

Detailed findings

Service vision and strategy

- The approach with respect to service vision and strategy was that of an evolving one. It was evident from discussions with the team that the service was well led with forward thinking and proactive Clinical Directors, of which there were two, and a Business Manager. We saw and staff informed us that the value base of the trust was openly discussed as part of the performance and development review (PDR) system. We observed staff who were passionate and proud about working within the service and providing good quality care for patients. We saw evidence of service improvement initiatives and regular monitoring of the quality of the service through clinical audit and other types of audit procedure.

Governance, risk management and quality measurement

- There was an effective governance framework in place to support the delivery of good quality care. Clinic leads were responsible for the day to day running of each clinic. They were responsible for cascading information upwards to the senior dental management team and downwards to the clinicians and dental nurses. The leads were responsible for the safe implementation of policies and procedures in relation to infection control, dealing with medical emergencies and incident reporting. The three senior nurses were each responsible for a locality and had a lead role in infection control, safeguarding or training and competencies.
- The quality and safety of dental services were discussed and presented at the Countywide Board by the Dental Service Manager. The dental service, one of the Clinical Directors and the Dental service Manager also reported to Gloucester Care Services leadership meetings and a Gloucester Doctors and Dentist Cabinet took place to discuss governance issues, the dental services were represented by one of the Clinical Directors.
- The service had an effective system to regularly assess and monitor the quality of service that patients received. Records of various checks, observation of completed audits and discussion with the senior team management confirmed a strong commitment to quality assurance and maintaining high standards. Issues were raised and discussed at staff meetings which ensured continual improvement.

Leadership of this service

- Staff felt valued in their roles within the service. The local management team were described as approachable, supportive and visible at all times. Clinicians stated that there is an open door policy with respect to the Clinical Directors and other senior staff working in the team, who was always on hand to provide professional support and advice. The majority of staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with senior managers would be acted on. The staff roles and responsibilities were clearly defined.

Culture within the service

- There was an open culture within the service. Staff told us they had opportunities to meet with team members, managers and members of the senior management team. For example, a range of meetings were co-ordinated at different intervals throughout the year to enable opportunities for staff to communicate and to share and receive information.
- Staff confirmed that they felt valued in their roles and that managers within the service were supportive, approachable and visible. The service had also developed a number of initiatives to share and receive information from staff. These included meetings every two months and annual Trust staff surveys.

Good

Are services well-led?

Public engagement

- The service gathered patient feedback from a range of sources. These included the Friends and Family Test, "Your Experience Counts" (a leaflet available to patients to leave their comments and send back via a freepost address), letters, emails and cards and from the NHS choices website.
- The service had produced a document "Patient Feedback – Are we listening?" to collate all the feedback and to look for themes and trends.

Staff engagement

- All the staff we spoke to were very patient focused and provided patient centred care. To facilitate this all staff had annual appraisals. A dental therapist we spoke with described how the Agenda for Change Knowledge and Skills Framework was used as part of the appraisal process. Several staff spoke of how the service management team had provided good support during challenging periods in their personal lives.
- There was a regular plan of staff meetings with each meeting held three times to ensure all staff had the opportunity to attend. We saw minutes of these meetings which showed that staff had contributed ideas for the improvement of the service. For example we saw that staff who carried out domiciliary care were asked if they wanted to make suggestions for the revised protocol.
- The Trust conducted an annual staff survey, however this was anonymised and not divided by service, therefore results relating specifically to the dental service staff could not be extracted.

Innovation, improvement and sustainability

- The culture of the service demonstrated to be that of continuous learning and improvement. For example, staff described how the dental nurses had undergone additional training in dental radiography and oral health promotion which enabled the service to provide enhanced care for patients.
- We saw an example of innovative work carried out by the department. A short video had been made to demonstrate to care workers how to deliver preventative dental care to a patient with dementia. The video consisted of two parts, one part demonstrating a poor approach to care and the other showing best practice and how this would ensure a good outcome for the patient. The video was used to initiate discussion at training sessions for community and care home staff.