

Coventry and Warwickshire Partnership NHS Trust

RYG

# Community dental services

## Quality Report

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# Summary of findings

## Locations inspected

<b>Location ID</b>	<b>Name of CQC registered location</b>	<b>Name of service (e.g. ward/ unit/team)</b>	<b>Postcode of service (ward/ unit/ team)</b>
RGYCR	Wayside House		

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership 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 Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership 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?	Good	
Are services well-led?	Good	

# Summary of findings

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# Summary of findings

## Overall summary

Overall, we rated the service as good because:

- Staff reported incidents appropriately. Incidents were investigated, shared, and there was evidence of lessons learned.
- Staff understood their safeguarding responsibilities and were aware of the safeguarding policies and procedures. Staff had up to date safeguarding training at the appropriate level.
- Medicines were stored, handled and administered safely.
- Equipment was well maintained and fit for purpose.
- Staffing levels were appropriate and met patients' needs at the time of inspection.
- Patients' individual care records were comprehensively written in a way that kept patients safe. Relevant information was recorded appropriately and staff had access to relevant details before providing care.
- Standards of cleanliness and hygiene were generally well maintained.
- Mandatory training was provided for staff and compliance was 100% for most topics. There was an action plan for the one topic, which did not meet the trust target of 95% compliance.
- Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Further training and development opportunities were available for staff.
- Appropriate systems were in place to respond to medical emergencies.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- The service followed effective evidence based care and treatment policies that were based on national guidance.
- There was evidence of good multidisciplinary working with staff. Teams and services worked together to deliver effective care and treatment.
- During the inspection, we saw and were told by patients, that all staff working in the service were kind, caring and compassionate at every stage of their treatment.
- Patients were treated respectfully and their privacy was maintained in person and through the actions of staff to maintain confidentiality and dignity.
- Staff were sensitive to the needs of all patients and were skilled in supporting patients and young people with a disability and complex needs. We saw there were systems to ensure that services were able to meet the individual needs, for example, for people living with dementia and a learning disability.
- Staff involved patients and those close to them in aspects of their care and treatment. Information about treatment plans was provided to meet the needs of patients.
- There was an effective system to record concerns and complaints about the service. Complaints were reviewed and actioned appropriately with a view to improving patient care.
- Staff told us that they felt supported by their immediate line managers and that the senior management team were visible within the department.
- There was a very positive and forward looking attitude and culture apparent among the staff we spoke with.

However, we found that:

- Not all staff followed standard infection control precautions at all times.
- Some medical records were not locked away securely, although there was limited public access to this area.
- The service was unable to provide evidence of water quality monitoring and the results of water quality checks.
- Dental staff did not always ensure they followed their own policy on obtaining and recording informed consent.

# Summary of findings

- There were frequent inappropriate referrals into the service, which led to delays in the provision of treatment for some patients. However, the service had taken steps to reduce these and there was evidence that the number of inappropriate referrals had reduced.
- The newly developed dental strategy covered the period from 2016 to 2020. It was not fully operational

as it relied on a dental plan that was incomplete at the time of our inspection. However, staff told us the plan was a work in progress and that it would be completed. The plan did not contain dates when the actions should be allocated, reviewed or completed by.

# Summary of findings

## Background to the service

Coventry and Warwickshire Partnership NHS Trust provide community dentistry for patients of all ages who need specialised dental care that is not available in general dental practices. This includes oral health care and dental treatment for patients with an impairment, disability and/or complex medical condition. Patients with physical, sensory, intellectual, mental, medical and emotional needs are treated in the service and provision is also available for patients who are housebound or homeless.

The dentistry services are based at the City of Coventry Health Centre where there are nine treatment rooms. There is also a mobile dental unit, which is used to provide dental services to special schools and a rehabilitation establishment. The service is open 9.05am to 4.30pm Monday to Thursday and 8.50am to 4pm on a Friday.

Minor oral surgery is available through a contract with local NHS commissioners. There is a plan to provide conscious sedation starting from August 2017. General

anaesthesia services are available in partnership with a local NHS trust if required, for very young or extremely nervous patients and those with individual needs who require multiple extractions.

From April 2016 to March 2017, the dental service carried out 11,343 patient appointments. This included 1,181 appointments using the mobile treatment centre, 2,063 home visits and approximately 110 children's appointments, plus 44 special needs appointments, for treatment to be carried out in a local hospital under general anaesthetic.

During our inspection, we inspected the dental service at the City of Coventry Health Centre.

This was a Care Quality Commission focussed follow up inspection. We carried this out because of concerns identified during our inspection in April 2016, when Coventry and Warwickshire Partnership NHS Trust dental services were rated as requires improvement overall. The service then was rated good for effective and caring and requires improvement for safe, responsive and for being well-led.

## Our inspection team

Our inspection team was led by:

**Team Leader:** James Mullins, Head of Hospital Inspection (Mental Health), CQC.

The team included a CQC inspector and a dentistry special advisor.

The team would like to thank all the staff who met and spoke with them during the inspection.

## Why we carried out this inspection

We inspected this core service as a follow up comprehensive inspection.

## How we carried out this inspection

We visited the community dental service at the City of Coventry Health Centre.

We spoke with 12 staff in the service. Staff spoken with included dental nurses, dentists and managers. During our inspection, we spoke with four patients.

# Summary of findings

We looked at three sets of records in the service, which included treatment plans, risk assessments and service specific documents.

We looked at records and the trust's performance data.

To get to the heart of patients who use services' experiences 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 inspecting, 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 inspection on 27 June 2017. During the inspection, we held focus groups with a range of staff who worked within the service, such as dental nurses, dentists and dental therapists. We talked with patients who used services. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of patients who use services. We met with patients who use services and carers, who shared their views and experiences of the core service.

## What people who use the provider say

Some of the recent comments we saw made by patients included:

'Thanks you for all your care and gentleness with my dental needs'

'Thank you for making the process of having braces nicer by being so friendly and helpful'

One patient commented that staff always treated her son, who was living with a disability, with dignity and respect.

## Good practice

- The service coordinated treatment input for patients living with complex needs who were undergoing general anaesthesia. This included podiatry, venepuncture and other interventions which would be distressing to the patient. This also reduced the number of health care attendances require by patients.

The oral health education and promotion team provided effective care and treatment to patients in the community setting by visiting schools, rehabilitation centres and voluntary organisations in the community. It also reached out to homeless patients living in the city of Coventry.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the service **SHOULD** take to improve

- Ensure that actions on the service development plan are assigned and carried out in order that the newly developed strategy can be executed effectively.
- Appropriate measures should be taken to ensure that confidential patient records are stored securely at all times.

- Ensure that the all of the required safety checks have been carried out as per water safety regulations for the control of legionella, in both the water systems in the mobile dental unit and in the dental health centre. Service leads should have oversight of these risks and checks which should be reported on regularly at governance meetings.
- All staff should follow standard infection control precautions for every process with every patient.

# Summary of findings

- Ensure that consent to care and treatment is always obtained in line with legislation and guidance.

# Coventry and Warwickshire Partnership NHS Trust

## Community dental services

### Detailed findings from this inspection

Good 

## Are services safe?

### By safe, we mean that people are protected from abuse

We rated the service as good for safety because:

- The dental service used the trust's electronic incident reporting system to identify and investigate safety incidents.
- Staffing levels were adequate to meet patient need at the time of our inspection. There was a good staff skill mix across the service.
- Radiography was maintained by specialised technicians to ensure it was safe to use and X-ray equipment was maintained according to recognised safety guidelines.
- Equipment and medicines required for medical emergencies were maintained in accordance with Resuscitation Council and British National Formulary guidelines.
- Dental service staff received adult and children safeguarding training and were confident in their knowledge of how to escalate concerns. Staff understood their responsibilities and had the appropriate level of safeguarding training.
- There were effective systems in place regarding the handling, storage and administration of medicines.
- Equipment was well maintained and fit for purpose.
- Patients' individual care records were written in a way that kept patients safe. Staff had access to patient information prior to providing patient care.

- Standards of cleanliness and hygiene were generally well maintained.
- Mandatory training was provided for staff and compliance was 100%, except for one topic, which did not meet the trust target of 95%.
- Appropriate equipment and processes were available to respond to medical emergencies.

However, we found that:

- Not all staff followed standard infection control precautions at all times and we were therefore not assured that patients were not being exposed to unnecessary risk of infection.
- Some medical records were not stored securely, although there was limited public access to this area.
- There was insufficient storage space for staff to store their personal belongings away from the clinical areas.
- The service was unable to provide evidence of water quality checks, although we saw a risk assessment for legionella. Actions from the risk assessment included regular water monitoring. We were told these had been undertaken by the landlord. However, the service had no oversight of water quality and we had no assurance that the quality of the water met the required standards of safety or that all of the actions from the risk assessments had been carried out.

# Are services safe?

## Safety performance

- The service monitored a range of safety information. This included safe use of sharps bins and safe standards for X-ray procedures.
- There had been no never events reported in dentistry services from February 2016 to January 2017.
- There had been no serious incidents reported to the Strategic Executive Information System from February 2016 to January 2017.

## Incident reporting, learning and improvement

- The clinical lead and the dental nurse manager were responsible for investigating incidents within the dental service.
- Staff understood their responsibilities to raise concerns, record and report safety incidents and near misses and how to report them. When things did go wrong, robust reviews were carried out. We saw evidence that the service was focussed on learning from incidents to make sure the safety of the service was improved.
- The trust had an electronic incident reporting system in place and standard reporting forms for staff to complete when something went wrong. Incidents which occurred in patients homes were also recorded using this system. A dental nurse we spoke with described how the system worked and told us they always received acknowledgment emails following submission of an incident form. We were told incidents were shared with staff through regular staff meetings and we saw evidence of this from the meeting minutes.
- All incidents were graded by level of harm and from January to June 2017, the dentistry service reported nine incidents, all with low harm or no harm. The dental nurse manager showed us examples of how they followed up issues resulting from reported incidents.
- Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no accidents or incidents, which had required notification under the RIDDOR guidance from June 2016 to June 2017.

- Staff were able to tell us about changes made as a result of incidents. For example, the changes made as a result of an appointment letter being sent to the wrong patient, which included an added checking stage.
- We saw there was evidence of some audits, which monitored safety performance. This included infection control, hand hygiene and X-ray quality and processing.

## Duty of Candour

- The dental nurse manager demonstrated an understanding of their duty of candour and staff we spoke with were able to describe examples of when duty of candour would be required. Duty of candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment. This includes informing patients about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. There had been no incidents requiring duty of candour reported in the year to June 2017.

## Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff we spoke with were aware of the trust's safeguarding policy and had received training appropriate to their clinical grade. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Staff had regular training in safeguarding of vulnerable adults and child protection. Those interviewed were able to provide definitions of different forms of abuse and were aware of safeguarding procedures, how to escalate concerns and relevant contact information.
- Safeguarding training was mandatory for staff and trust data provided showed that all staff in dentistry services had in date safeguarding training. This included 100% of staff with level 2 safeguarding children and adults training, and 100% of staff who required level 3 safeguarding children and adults training.
- One of the dentists was the appointed lead for safeguarding who attended trustwide meetings and fed back any updates to the rest of the dental staff.

## Are services safe?

- Safeguarding details and contact numbers were available for staff to call for advice and support regarding referrals. No safeguarding referrals had been made about the service in the year to June 2017.
- The service had in place a process to identify children and vulnerable adults who did not attend their dental appointments. Further follow up calls were made rather than a 'did not attend' letter returned to the referring dental practice.

### Medicines

- There were effective systems in place to ensure the safe use of medicines. This included safe systems for medication storage, stock control, prescribing, administration and disposal of unused/expired medications.
- Medicines were stored in locked cupboards or refrigerators. Where medicines required refrigerator storage, a daily log of temperature was maintained. However, recording of fridge temperatures had only just commenced in June 2017 and we were only able to check the previous four days recordings. Ambient room temperatures were recorded and we saw that from January to June 2017, these were within recommended ranges. Staff told us of the safety actions they would take if temperatures went out of normal ranges, including contacting pharmacy and reducing shelf life of medications.
- Emergency drugs were kept in a sealed bag and stored appropriately to enable rapid staff access. Medicines management for medical emergencies in primary dental care was in line with the guidance set out in the British National Formulary. The trust's pharmacy department had assessed the storage of the emergency drugs and found they were kept in an appropriate place.
- There was a comprehensive system for recording all prescribed medicines and prescription pads were stored in locked cupboards with each prescription number recorded by patient identification numbers. NHS prescriptions were stamped with an official centre stamp.
- Patient records included allergies and reactions to medication, such as antibiotics. Prescriptions and batch numbers of medication used were recorded in patient's records.

- Local anaesthetics, antibiotics and high concentration fluoride toothpastes were prescribed according to current clinical guidelines.
- The records we viewed were complete, and provided an account of medicines used and prescribed which demonstrated patients were given medicines only when necessary.
- The dental service did not audit its use of antibiotics for their appropriateness. However, there was a key performance indicator (KPI) target attached to the number of antibiotic courses prescribed in relation to the number of courses of treatment provided. From April 2016 to March 2017, the service achieved its KPI for the number of antibiotics prescribed.

### Environment and equipment

- The design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe.
- The dental equipment and the environment were clean and well maintained.
- There were arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH legislation requires employers to control substances, which are hazardous to health. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified.
- During our 2016 inspection, we saw that potentially hazardous to health cleaning materials used by the cleaners were stored in an unlocked room adjacent to the reception area and accessible by patients from the waiting room. During this inspection, we found the cleaners room locked at all times.
- During our 2016 inspection, we identified that the mobile dental unit did not have a risk assessment to ensure it was a suitable environment to undertake clinical care. During this inspection, we saw that a risk assessment was undertaken which went to the service Safety and Quality forum in June 2016 and was ratified at the directorate Safety and Quality group. The risk was now included in the service risk register and we were told all actions identified had been implemented. Although the mobile unit and all of the equipment

## Are services safe?

inside it had now been assessed and approved, the process had identified that a new mobile unit was required and we were told that a business case for this had been submitted.

- Waste was managed safely and clinical specimens were handled appropriately. This included the classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.
- The dental equipment including all the dental chairs and lights were fit for purpose and appeared to be well-maintained. Annual servicing details for both the intra-oral and extra-oral X-ray machines were available and up-to-date. We saw that the service had a comprehensive maintenance schedule in place for their equipment. Electrical testing had been carried out annually on other electrical items, including the blood pressure monitoring machine and the wheelchair recliner, and a label indicated when the next test was due.
- A wheelchair recliner was available in the Diaco surgery room. This enabled patients to be treated in their own wheelchair and eliminated the need to transfer into a dental chair. This room also had administration facilities including a computer, desk and filing cabinets in which paper patient records were stored. There was a separate drawer used to store staff coats and handbags. During our 2016 inspection, this room was highlighted as a concern because it was also being used for staff comfort breaks and had beverage-making facilities and was also being used for clinical treatment. During this inspection, staff told us they had carried out a risk assessment in the room to ensure it remained as safe as possible for staff and patients to use. We found the room had been decluttered and only essential items were stored there. Staff told us there were insufficient storage facilities for their personal belongings and in September 2016, an incident report had been raised by staff to formally record this. The incident had been signed off as 'no action' because no extra storage could be created. However, the infection control team had been made aware of the issues.
- There was a dedicated X-ray room containing an intra-oral machine and an extra-oral machine. Both machines had clearly identified and appropriately sited isolation switches to switch the machine off in an emergency. Clear signage and safety warning lights were in place in the X-ray room to warn patients about potential radiation exposure.
- There were systems in place to check and record equipment was in working order. These included annual checks of portable electrical appliances. The trust had contracts in place with external companies to carry out annual servicing and routine maintenance work of other equipment in the premises in a timely manner. This helped to ensure there was no disruption in the safe delivery of care and treatment to patients.
- The resuscitation equipment was secure and sealed and we found evidence that regular checks had been completed. An automated external defibrillator, portable suction machine, oxygen and associated breathing aids were available. Paediatric resuscitation equipment was also available in line with the Resuscitation UK and BNF guidelines.
- Guidelines were available to inform staff how to respond in the event of a sharps or needle stick injury. This included the immediate first aid procedure and reporting of the incident. We saw that safety devices were used to enable the safer disposal of sharps and this complied with the Safe Sharps Act 2013. However, during our inspection we saw one dentist who did not dispose of their own needle following a procedure and the dental nurse disposed of it instead. This is considered as not best practice as it increases the likelihood of a sharps injury occurring.
- Sharps bins were used safely. They were correctly stored, assembled, labelled and not overly full and were disposed of by the recommended use by date, all in accordance with the European Union directive for the safe use of sharps. An audit of sharps bins in January 2017 showed the dentistry services were 100% compliant with safety standards.
- The trust 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 was appointed and a nominated dentist was the radiation protection supervisor for the service.

## Are services safe?

- We saw the radiation protection file was complete and included the names of the radiation protection supervisor, the radiation protection advisor, a copy of the local rules and service documents for the X-ray machines.
- We found there were suitable arrangements in place to ensure the safety of the radiography equipment and we saw local rules relating to each X-ray machine displayed in accordance with guidance. X-ray audits were carried out monthly to ensure films were of a satisfactory quality. From September 2016 to April 2017, more than 70% of all X-rays were graded as a one, which denotes the highest quality, and less than 10% were graded in the lowest category. This falls within national guidance for acceptable reporting.
- Dentists recorded the reasons for taking X-rays in the patient's clinical notes. All images were checked for quality assurance and fully reported on.
- Domiciliary dental checks were carried out if it was not possible for a patient to attend a clinic. Domiciliary treatment included dental assessments and emergency care however, most interventions beyond cleaning or the application of a fluoride protective paste, were subsequently arranged to take place in the dental centre clinic.
- An audit of dentistry care records carried out in March 2016 showed the service was 100% compliant with trust standards for record keeping in all categories except the completeness of medication charts, for which it was 0% compliant and for having the correct admission paperwork for which it was 86% compliant. We were not provided with an action plan to address these issues and we did not see any further audits to measure improvement.
- We looked at three patient treatment records. This included a patient who lacked the capacity to make a treatment decision and who was treated in their best interest. We saw meetings had been held with other relevant healthcare professionals to discuss the treatment options.
- We did not observe a home visit. However, staff told us that dentists and therapists who provided domiciliary dental care took the relevant patient record to the patient's home and updated it immediately following assessment and treatment. During the domiciliary visit, the records were stored safely and remained with the dental practitioners at all times. Clear advice and written information was provided to the patient and relatives as appropriate.
- During our 2016 inspection, we found that paper patient records were stored in a series of filing cabinets, which were not locked, in one of the treatment rooms. Staff said they did not have a dedicated store room for patients' records and that this surgery was not used regularly. We were told the storage system was temporary until a long term solution could be found. During this inspection, we found this storage issue remained the same. We saw that the treatment room door was open and that the keys to the unlocked filing cabinets were in the filing cabinet lock. Staff told us that patients did not have unaccompanied access to the dental corridor. However, there was a risk that unauthorised persons could access confidential patient information. This was not on the service risk register.
- Electronically stored records were password protected and only accessible to staff who had an appropriate security password.

### Quality of records

- Patients' individual care records were written and managed in a way that kept patients safe.
- There was a mix of computerised and paper records. However, the service was working towards a 'paper light' system with the aim of eventually having all patient records available electronically via a computer. All new patients had electronic only records but some older patients' records were still paper based. There was a plan to scan all paper records and create new electronic files for every patient. At the time of our inspection, this work was ongoing and no completion date had been set.
- Records seen were accurate, complete, legible, and up to date. Patient records were maintained in accordance with trust policy. Each patient contact with a dentist was recorded in the patient's care record. We observed and were told records were completed at the time of treatment.

### Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained.

## Are services safe?

- The waiting room, surgeries and treatment areas all appeared to be clean and tidy and free from clutter. An environmental cleaning audit carried out in May 2017 showed the clinical areas scored 97% overall for cleanliness. Areas for improvement were identified on an action plan and included removal of dust and clearer labelling for clinical waste bins.
- The service did not carry out any of the twice yearly Infection Prevention Society Audits which are recommended in national guidance, Health Technical Memorandum HTM 01-05 (guidelines for decontamination and infection control in primary dental care), (HTM 01-05). This audit was designed primarily for primary care dentistry but its use is considered best practice in all dentistry services because it identifies all aspects of infection control in dentistry practice, rather than just environmental cleanliness. For example, the use of this audit would identify that dental staff were following the correct procedure for the rinsing of used dental instruments and the safe disposal of sharps.
- The service used an external provider to decontaminate and sterilise its dental instruments. The trust told us it had assurances contained within their service level agreement with the provider that the standards of decontamination used met all the essential requirements of guidance contained within HTM 01-05. Clean instruments were received prepacked on trays wrapped in drape cloths. These were stored in a “clean” utility room and labelled with what they were and the date they needed to be used by or re-sterilised. The trays were unwrapped within the treatment room immediately prior to use. Following treatment, the instruments were re-wrapped in the drape cloth and taken to the “dirty” utility room where they were stored in lidded boxes awaiting collection to be taken by the external provider.
- A system of logging and barcoded stickers was in use to ensure that instruments used on individual patients could be identified retrospectively if required. In addition, individual instruments were available in autoclave pouches so that a complete kit would not have to be used if not necessary.
- We observed the use of instruments during treatment of an orthodontic patient and during a tooth extraction. Appropriate infection control precautions were taken prior to and during the treatment. However, following one of the procedures, the dental nurse washed tooth extraction forceps in the hand hygiene sink. Hand hygiene sinks must be dedicated to the sole purpose of hand washing (Health Building Note 00-09) (HBN 00-09) otherwise there is a risk of bacteria from a patient becoming colonised in the water supply, which may result in patient harm. All staff have a duty to follow water safety policies and to prevent contamination of the water supply.
- The service showed us a risk assessment for legionella, which had been carried out in January 2017 for the mobile dental unit and one for the treatment rooms at the City Of Coventry Health Centre which had been carried out in January 2016. The mobile dental unit risk assessment had some recommended actions. The risk assessment for the City of Coventry Health Centre showed there were three ‘high risks’ for which the service was non-compliant and three partially non-compliant high risks. Additionally, there were three ‘medium’ risks, for which the service was non-compliant. We were not provided with evidence that the recommended actions from the risk register had either been carried out or were being regularly monitored. One ‘high risk’ action had been completed more than 12 months post assessment, in May 2017. We were therefore unsure if the service was operating safe water systems to ensure the control of legionella.
- We were told that there was a process in place to monitor the water temperature from the standard domestic hot and cold water taps in the dentistry clinic. However, the trust was unable to provide evidence of these checks or of the results reported. We were told that water safety was the responsibility of the landlord of the building and that the dentistry service relied on them to meet the national guidance on the control of legionella.
- Hand washing facilities were available in each treatment room and included liquid soap and paper towels. Hand hygiene posters were on display next to all sinks to remind staff of the correct procedure for hand washing. All staff were observed to be arms bare below the elbows to enable good hand hygiene practices.

## Are services safe?

- The dirty utility room had a dedicated hand-washing sink and one other sink. This enabled staff to wash their hands in a dedicated clean sink and to wash any equipment separately.
- Hand hygiene audits were carried out monthly and from June 2016 to May 2017 compliance was reported as 100%.
- Hand sanitising gel dispensers were available in clinical rooms and we observed staff using the gel before and after patient contact.
- Personal protective equipment was available for staff (including gloves, masks or visors, safety glasses and aprons) and for patients (safety glasses and bibs). We observed these being used appropriately to aid effective infection control.
- Foot operated clinical waste bins were available in all clinical rooms. However, we observed one member of staff repeatedly opening the bin lid using their hands. This meant that any dirt or germs from the bin lid could be transferred around the environment and onto patients.
- Clinical waste was labelled and in the appropriate orange coloured bin liner bags. Other bins with black bags for general waste were also available.

### Mandatory training

- The service had a mandatory training programme that included basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, Mental Capacity Act 2005, equality and diversity and manual handling.
- The target for mandatory training compliance was 95%. In January 2017, medical and dental staff in this service exceeded this in all categories except immediate life support (ILS) which was 80% compliant. We saw that the two staff with outstanding ILS training were both booked onto courses in June 2017.
- There was an induction programme for all new staff. This included both a trustwide induction and a local induction. Staff who had attended this programme said it met their needs. We saw a completed induction record check list for a new member of staff. As part of

the service's new dental plan, role specific induction pathways were being looked at with set objectives and assessments for each job role. At the time of our inspection this work was ongoing.

- Staff told us mandatory training met their needs and that they did not have any difficulties accessing training.

### Assessing and responding to patient risk

- During our 2016 inspection, we found that several risk assessments in the dental service were not in place. This included dental hygienists' community visits, the Diaco room, and the mobile dental unit. During this inspection, risk assessments had been completed for these identified risks. However, staff told us that they did not always carry out a risk assessment for every domiciliary visit but carried out an assessment when they believed it was indicated, for example, if there was a large dog in the house.
- During our 2016 inspection, we identified that there was no risk assessment for staff and patients who were using the dental services theatre department at a local hospital. During this inspection, we found a risk assessment had been completed. Staff told us this included the following of policies and guidelines belonging to the local trust when using their facilities. Staff who worked at the local trust confirmed they had good access to these policies and guidelines. No incidents had been reported which related to offsite treatment.
- Comprehensive medical history questionnaires (MHQ) were completed by or for each patient at their first appointment and updated at subsequent visits. The MHQ included information about the patient's medical history and medication.
- Patients undergoing general anaesthesia were assessed using the American Society of Anaesthesiologists classification system in accordance with current guidelines.
- Full examinations were carried out on each patient at each check-up including soft tissue examination, periodontal examination, occlusion (bite) and diet.
- During our 2016 inspection, we found the dental waiting list had over 400 patients waiting for treatment and that there was no oversight of the risks associated with this. During this inspection, we found that there was a risk

## Are services safe?

assessment for patients on the waiting list and that there was now a system in place which ensured that dental managers were fully aware of their waiting times and numbers of patients waiting to be seen. Systems had been implemented to effectively manage the waiting list and ensure patients received treatment in a timely manner. Staff showed us how the system they had developed recorded every referral and each stage the patient was at in their treatment journey.

- Referrals were assessed against the established access and exclusion criteria and either accepted by the service or not. Any patient who was not accepted by the service because they did not meet the criteria were sign posted back to their general dental practitioner and staff also contacted the referring service to advise them of this.
- Dental general anaesthesia (GA) was delivered following the World Health Organisation five steps to safer surgery check list to prevent incidents, such as a never event from occurring. Staff ensured patients and carers received appropriate post-operative instructions following dental surgery under GA. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage (bleeding) and infection.
- The trust had identified a radiation protection supervisor. We observed signs in the radiology room to prevent patients entering areas that would place them at risk of radiation exposure.
- Resuscitation equipment was available in the service.
- There was a protocol in place to manage deteriorating patients and a system was in place to call 999 when required.

### Staffing levels and caseload

- Staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance. Staff told us there were always enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe.
- There were 24 whole time equivalent (WTE) staff employed in the dental service. This included six dentist staff and 16 dental nursing staff.

- Actual staffing levels met the planned levels at the time of the inspection. There were no vacancies reported in the medical and dental staff group. However, the vacancy rate for dental nurses was 5%. This was better than the average for the rest of the trust.
- Arrangements for using bank, agency and locum staff were designed to keep patients safe and included an appropriate induction process. However, from April 2016 to March 2017, we were told the service did not use any temporary bank and agency workers.
- The average sickness rate for staff in this service from April 2016 to March 2017, was 7%, which was 1% worse than the whole trust average. Sickness was most common among the administrative and clerical staff group where it was 10%. Sickness among clinical staff averaged at 6%.
- The appointment system was tailored to patients' needs so that sufficient time was allocated for assessment and treatment in response to the complex needs of the patients. Patients told us that they rarely had to wait past their allocated appointment time.
- The acting clinical lead for dentistry was due to retire in the summer of 2017 and a replacement substantive lead dentist was in post. At the time of this inspection, they were on maternity leave.
- Staff roles and responsibilities were clearly defined. There were dedicated staff who provided regular domiciliary care and regular staff who provided dental service to patients under general anaesthesia. The service employed oral health educators and dental therapist as well as dentists and dental nursing staff.
- Dentists and nurses provided cover to clinics other than their own regular clinic during annual leave and sickness.

### Managing anticipated risks

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- One of the senior dental nurses was responsible for the management of medical emergencies. She showed us the systems available to treat such an emergency. These were in line with the Resuscitation Council UK guidelines and the BNF. Appropriate emergency

## Are services safe?

equipment and an automated external defibrillator were available. Oxygen, suction machines and medicines for use in an emergency were available and were stored securely. Spares were available from a walk-in centre in another part of the building.

- The emergency equipment was checked each day by a senior dental nurse. The results of these checks were logged and initialled by the person completing them. We saw examples of these logs for both current and past months.
- Biohazard spillage (for example blood) and mercury spillage kits were available if needed.
- Dentists told us there were always two dentists in the operating theatre while patients were having treatment under general anaesthetic. This meant a second opinion was immediately available when required.
- There was a named radiation protection adviser and a radiation protection supervisor who ensured the service

complied with their legal obligations. Ionising Radiations Regulations 1999 (IRR99) are a statutory legal requirement for the use and control of ionising radiation in the United Kingdom.

- Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were in place. This is a reporting mechanism published by the Department of Health, September 2012 which requires services to report any radiation exposures which are given at a higher rate than intended. The community dental service had not submitted any IRMER reports from June 2016 to June 2017.
- All health and safety policies and procedures were available and accessed through the trust's intranet.
- Managers and staff told us, an emerging risk was the increasing demand on the service. Activity was being reported to the clinical commissioning groups to reflect this increase.

## 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.

We rated the service as good for effective because:

- Patient need was assessed and their care and treatment was delivered following local and national guidance for best practice.
- The service had effective evidence based care and treatment policies based on national guidance. This included special care dentistry and preventative dental care.
- An audit of orthodontic care showed that the standards of orthodontic treatment had been maintained in line with, or better than the national recommendations.
- We saw evidence of multidisciplinary working between staff, teams and services working together to deliver effective care and treatment.
- Staff had the necessary qualifications and skills they needed to carry out their roles effectively.
- Staff, registered with the General Dental Council had frequent professional development and clinical supervision which met their professional registration requirements.
- Staff were supported to maintain and encouraged to further develop their professional skills and experience appropriate to their roles.

However, we found that:

- Consent to care and treatment was not always obtained in line with legislation and guidance.

### Evidence based care and treatment

- The service followed national and local guidance including guidance published by the Royal Colleges, British Dental Association and National Institute for Health and Care Excellence (NICE). Nice guidance followed included; NG30, oral health promotion, general dental practice and NG 48, oral health for patients in care homes.
- Dentists, dental therapists and dental nurses working in the service used national guidelines to ensure patients received the most appropriate care. This included

guidance produced by the British Society for Disability and Oral Health (BSDH) and the Faculty of General Dental Practice. Dentists and dental nurses we spoke with were fully aware of these guidelines and the standards that underpinned them.

- Clinical audits demonstrated the implementation of national guidance including, consent and dental erosion.
- Patient dental recall intervals were determined using a risk based approach based on current NICE guidance.
- NICE guidelines and guidance from the Faculty of General Dental Practice on antibiotic prescribing and the taking of radiographs was also used.
- Consultations, assessments and care planning and treatment were carried out in line with recognised general professional guidelines.
- The service used an assessment form for dental erosion that was designed based on Basic Erosive Examination System and Basic Erosive Wear Examination System national guidelines.
- The service received national patient safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency. Where relevant, these alerts were shared with all members of staff by the dental nurse manager at staff meetings.
- The service delivered dental general anaesthesia (GA) 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.
- Special Care Dentistry for patients with complex medical, mental health and social impairments was delivered according to best practice as set out by the BSDH including domiciliary care. Policies were in place to ensure patients were not discriminated against. Staff were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- Policies we reviewed reflected national guidance with appropriate evidence and references. Staff we spoke with could direct us to these policies.

## Are services effective?

- We observed patients and carers being provided with clear verbal and written instruction following treatment. For example, the avoidance of drinking or eating for half an hour after fluoride treatment reflected best practice.
- The dental records of consultations observed during the inspection, included clear plans of care, which reflected best practice, including the record of discussions with patients and carers about planned treatments and oral health.

### Pain relief

- Dentists assessed patients appropriately for pain and other urgent symptoms. For example, in cases of very young children where local anaesthesia was not appropriate for tooth extraction, GA under the care of a hospital anaesthetist was used as an alternative.
- Patients were appropriately prescribed local anaesthesia by dentists for the relief of pain during dental procedures, such as dental fillings and extractions.
- Patients who were needle phobic were given extra time for procedures and distraction techniques were used where possible. A patient having treatment during our inspection told us their extraction was pain free.
- Patients were given advice on options of medications to take post treatment, should the patient require pain relief once at home.

### Nutrition and hydration

- Children and adults having procedures under GA were appropriately advised by dentists about the need to fast before their procedure.
- Patient advice and information leaflets were available which provided nutrition and hydration advice for patients. These included written and pictorial representations, which were appealing to adults and children.
- The oral health education team provided dietary advice to help patients look after their teeth. This included advice on limiting sugary intake and healthy snacks.
- Water was available in the waiting area for patients and there was a café on the ground floor on the health centre selling drinks and snacks.

### Patient outcomes

- The service participated in some local assessments to monitor the quality of service patients received. This

included audits of clinical records, dental radiography quality, hand hygiene and environmental cleanliness audits. Results were fed back to the board as part of the performance monitoring programme.

- The dental service participated in one monthly local audit. This audit was undertaken to continually monitor the quality of radiography equipment and film images by comparing them to national set guidance. We were shown the results of an audit across the service of radiograph quality for radiographs taken from January to June 2017. Outcomes from this audit were satisfactory.
- Preventive care across the service was delivered using the Department of Health's 'Delivering Better Oral Health Toolkit 2013'. Adults and their carers attending services 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.
- Oral health was promoted in the community by a dedicated team of dental oral health educators.
- The service had carried out an audit on the condition of teeth among all five year old children in the city of Coventry from October 2016 to February 2017. This included examining 1,800 children's teeth using the mobile dental unit to travel to schools across the city. The survey was commissioned by Public Health England and results were due to be published in summer 2017.
- The service carried out an audit for 'Quality Outcome of Peer Assessments Ratings (PAR) for Completed Orthodontic Treatments 2015/2016'. PAR is an index for the assessment of the standard of orthodontic treatment achievement. The British Orthodontic Society Clinical Standards Committee Guidelines state for a dentist to demonstrate high standards, the proportion of their patients reporting 'worse' or 'no difference' category following treatment, should be less than 5%. The proportion of patients reporting 'improved' or 'greatly improved' following treatment should be higher than 70%. The audit showed that the average reduction in PAR scores was better than the benchmark at 76.5% and that only 2% of cases fell into the worse or no different category, which was better than the

## Are services effective?

benchmark of 5%. The PAR scores for the year 2013/2014 for better and no difference categories were reported as 78.5% and 2%. The service was participating in this audit for the year 2017/2018.

- An audit of dental erosion amongst patients using the service was underway at the time of our inspection and results were not available. The Tooth Surface Audit tool was used for this measure and had previously been undertaken by the service in 2014.
- The service met the patient outcome measure for antibiotic prescribing set by the local NHS commissioners. This was to ensure less than five percent of all patients were prescribed antibiotics following their treatment.
- Patient information was recorded at each visit using a series of questions within the electronic patient record system to identify each patient's dependency. This enabled the service to plan an appropriate time allocation for patients with complex needs and therefore facilitate the best outcomes for these patients.

### Competent staff

- The service encouraged staff to undertake additional professional training to manage the increasing complexity of patients. This included dental nurses undergoing training in conscious sedation and training dental staff to become orthodontic therapists. The dental service placed great emphasis on the benefit of using extended duty dental nurses and we found that most dental nurses had further training in relation to dentistry, oral health promotion, dental radiography and fluoride varnish applications.
- Information provided by the service showed staff were up to date with their training. The training covered all of the mandatory requirements for registration issued by the General Dental Council.
- All staff had received regular annual appraisals. From April 2016 to March 2017, 100% of dental staff had received their annual appraisal. This exceeded the trust target of 95%. Staff were positive about their appraisal stating they had clear objectives and follow up one-to-one meetings with their managers.
- All staff received clinical supervision. Clinical supervision rates either met or exceeded the trusts target rate of 100% for all groups of staff groups working in the dental service. Clinical supervision was recorded in staff files.

- New staff underwent an induction process which lasted several weeks. Staff received extra support during their induction period. Induction training included mandatory training, a period of shadowing and a checklist of skills and knowledge which had to be signed off to confirm competency levels.

### Multi-disciplinary working and coordinated care pathways

- There were suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. There was effective collaboration and communication amongst all members of the multidisciplinary team to support the planning and delivery of patient centred care.
- Details of all treatment patients had received were communicated back to their referring dentist when they were discharged from the service at the end of their course of treatment.
- Dental care was coordinated with other multidisciplinary health care teams including oral and maxillofacial surgeons, acute liaison teams and speech therapists. Furthermore, coordination of hospital theatre sessions for patients with complex needs could be arranged. For example, when patients were undergoing a general anaesthetic procedure, the podiatry team could also attend to the patient at the same time.
- The dental service linked with other departments and organisations involved in the patients' journey such as GPs, support services and the local hospitals.
- The service maintained close working relationships with children's centres, the school nursing service, health visiting teams, learning disability teams and drug and alcohol support to ensure that vulnerable groups requiring dental care received treatment in a timely manner.

### Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, and discharge.
- There were clear mechanisms for sharing appropriate information with patients' GPs and other relevant professionals and to ensure that the patient and carers fully understand what was happening and any next steps.

## Are services effective?

- The service recognised the potentially detrimental effects on a patient's dental health if they could not access the treatment they required within an appropriate timeframe. A waiting list coordinator in dentistry ensured that all referrals and discharges were dealt with in a timely manner. New referrals were screened to ensure they met the referral criteria and were fully completed. Referrals that were not complete were returned to the referring practitioner.
- There were clear referral systems and processes in place to refer patients into the service which ensured the efficient use of NHS resources. We were told that the dentistry service had recently updated and republished its referral criteria and that this had been made available to all local dentists. However, we saw from waiting lists that there were still inappropriate referrals occurring every week and staff acknowledged that this remained an area of concern. In order to reduce the number of inappropriate referrals the service was attempting to increase awareness of its acceptance criterion with local dentist and commissioners.
- Referrals were made by general dental and medical practitioners and other health care professionals and residential care homes. We saw an effective system in place to ensure that referrals were managed without any undue delay to patients. All patients were seen within the 18-week target.

### Access to information

- Patient information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- Staff were able to access patient information, such as diagnostic imaging records and reports, medical records and referral letters appropriately through electronic records and some paper records. Access to electronic records was password protected. Records were updated by dentists and dental nurses directly after each consultation.
- All staff had access to the trust intranet to gain information relating to policies, procedures, and NICE guidance.
- Clinic information was shared with the patients' general dental practitioner or other health professional in letter format. The service produced these letters following the appointment and sent copies to their general dental practitioner or other health professional. Copies were provided for patients.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the legal requirements of the Mental Capacity Act 2005 (MCA) and told us how they applied these requirements when delivering care.
- Staff had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.
- All staff received mandatory training in consent, safeguarding vulnerable adults and the MCA, and understood the relevant consent and decision making requirements of legislation and guidance.
- Staff compliance with MCA training was 100%. A training needs analysis carried out by the service indicated that the Deprivation of Liberty Safeguards training was not required for dentistry staff.
- We were shown the dedicated forms used to gain consent from patients for their treatment. These forms were comprehensive and appropriate for their use. They included spaces for signature and date for the treating dentist, patient, carer/guardian and translator. The form was carbonated so that one copy could be given to the patient and the other kept in the patient record.
- Dedicated forms were used to gain consent from patients who did not have the capacity to make their own treatment decisions. These were comprehensive and appropriate for their use including a flow chart and space for a second opinion dentist to sign. We saw an example of a completed consent and best interest form.
- There was a system for obtaining consent for patients undergoing general anaesthesia, and having operative dental treatment. Staff discussed treatment options, including risks and benefits with each patient and their parents, guardians or carers. Responsible adults were asked to read and sign these before starting a course of treatment.
- Dentists had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to children and the adults responsible for their care. The dentists felt that responsible adults and older children should be given time to think about the treatment options presented to them. This ensured that a parent or older children could withdraw consent at any time. However, we saw that dental staff did not always ensure they followed their own policy on obtaining and recording informed consent.

## Are services effective?

- We saw an audit of 'consent 3' forms, which was carried out in December 2016. Consent 3 forms are used for a patient who agrees to a treatment being carried out while they remain awake. The audit was designed to ensure valid consent was always obtained and to assess how well staff adhered to the trust's consent policies and procedures. This audit had been undertaken as a result of issues identified in previous consent audits carried out in 2014 and 2015. However, we saw that findings from the 2016 audit identified that compliance to the consent policy had gone down for most categories audited. For example, the name of the procedure and also the provision of an explanation of the procedure when the medical term was unclear, had

both gone down from 86% compliant in 2014 and 2015 to 78% in 2016. Similarly, the health professional signing the form to indicate they have explained the process to the patient/parent and that the health benefits had been explained, had gone down from 86% to 78% compliant. Obtaining and documenting the name of the person with parental responsibility had improved from 72% to 100% but obtaining that named person's signature had fallen from 84% to 76%. Actions to improve compliance included discussion of the audit results at the safety and quality group and to remind staff to complete a form for every surgical procedure to embed consent as everyone's responsibility in the team.

## Are services caring?

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

We rated the service as good for caring because:

- During the inspection, we saw that all staff working in the service were kind, gentle and caring to patients throughout their treatment.
- Patients were treated respectfully and had their privacy and dignity maintained at all times.
- Staff involved patients and those close to them in aspects of their care and treatment.
- Patients we spoke with during our inspection were very positive about the way they were treated. The Friends and Family Test results were in line with England averages.
- Staff were sensitive to the needs of all patients and were skilled in supporting patients and young patients with disabilities and complex needs. Staff recognised the different requirements of each patient and treated them as individuals.
- Staff we spoke with were very dedicated to providing the best possible care for all of their patients.
- Staff used the Modified Dental Anxiety Scale to assess the level of anxiety in nervous dental patients so that appropriate care could be taken during their treatment.

### Compassionate care

- Staff were observed being kind, compassionate and caring while interacting and treating patients.
- We observed staff treating patients with dignity and respect. We heard and observed staff using language that was appropriate to patients' age or level of understanding. They used previous attendance notes and patient knowledge to communicate in a manner which met the individual's needs. Patients who attended frequently were known to the staff treating them. Nurses and dentists spoke clearly to patients and used respectful touch to reassure individuals when needed.
- Personal dignity was maintained at all times, ensuring doors were closed to prevent others entering. We observed treatment room doors were closed during our inspection when patients were with dentists. Conversations between patients and their carers and dentists could not be heard from outside the rooms.
- Staff told us they ensured longer appointment slots were available for very anxious or nervous patients. For

example, we were told about an adult patient who previously required a general anaesthetic for every filling. However, through the care and consideration shown by staff in this service, the patient was now able to undergo treatment without a general anaesthetic or sedation.

- Patients could be accompanied by friends or relatives during consultations if they wanted to.
- The Friends and Family Test, which assesses whether patients would recommend a service to their friends or family, showed that 93% of patients would recommend the service to family and friends.
- There had been 91 compliments recorded in the service from February 2016 to January 2017.
- Dentists and dental nurses spent extra time preparing in advance for patients with special needs. This included ensuring all staff involved in the patient's care and treatment were fully aware of the specific individual needs of the patient. Staff discussed in advance any problems they envisaged so everyone was prepared to carry out the consultation as quickly and efficiently as possible, whilst reducing stress and anxiety for patients as much as possible. Staff used the Modified Dental Anxiety Scale to assess the level of anxiety in nervous dental patients so that appropriate care could be taken during their treatment.

### Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment and said they felt appropriately involved in the planning of treatment.
- New patients and their carers were asked to complete a comprehensive medical history and a dental questionnaire. Staff were available to help with the form if required. This questionnaire enabled the clinicians to gather important information about their previous dental, medical and relevant social history. They also aimed to capture details of the patient's expectations in relation to their needs and concerns. The information was used to help decide on the most suitable treatment option and ensured comprehensive information was recorded and always available to protect the well-being of each patient.

## Are services caring?

- Patients understood when they would need to attend the service again for further treatment. Patients we spoke with were clear about what appointment they were attending for and what to expect plus who they were going to see.
- Patients said they were kept informed of the clinic waiting times. Staff worked hard to keep appointments running on time. There were no delays on the day of our inspection.
- Young children and patients with a learning disability were given time and support to understand what was involved in their treatment. Dentists and dental nurses spoke directly to the patient but also included their carer in explanations and discussions.
- Orientation sessions were arranged for patients wanted to see the dental clinics before they had any treatment. This helped them become familiar with the environment and reduced their anxiety.
- Patients were informed of the range of treatments available and their cost in information leaflets. NHS charge rates were available in the clinics. There was a wide range of dental information leaflets for specific dental care. This included, new denture care, mouth care and diabetes, acid erosion and improving access to psychological therapies.
- 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 care 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 any cost involved.

### Emotional support

- Staff were clear on the importance of emotional support needed when delivering care and fully understood the emotional impact dental treatment could have on a patient's well-being. For example, staff would attend the patient's home to carry out initial assessments for treatment if it was too difficult for the patient to attend the clinic. They understood the individual needs of each patient and always tried to ensure the emotional impact was minimised. We saw notes where the dental team had liaised with the patient's psychological support team to ensure appropriate care was being provided.
- Staff showed patience and understanding when interacting and treating patients. We saw and we were told by patients that they provided timely support and information to help patients cope emotionally with their treatment.
- Staff had a good awareness of patients with complex needs and those patients who may display anxious or challenging behaviour during their visit to the service.

## Are services responsive to people's needs?

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

We rated the service as good for responsive because:

- Dental services were flexible and provided community services close to patients' own homes, including where necessary, a domiciliary service. A mobile dental unit travelled to specialist schools within the county to reach out to children with complex needs.
- General dental practitioners and other health professionals referred patients to the service for short-term specialised treatment as well as long-term continuing care. The service and commissioners had developed a set of acceptance and discharge criteria so that only the most appropriate patients were seen.
- There were systems to ensure that services were able to meet the individual needs of patients, for example, for patients living with dementia or a learning disability.
- The service planned to take account of the needs of different patients reflecting the diversity of the local community. Patients from all communities could access treatment in the service if they met the referral criteria.
- There was effective multidisciplinary team working which linked with other care providers to ensure the right care was provided without avoidable delays.
- The oral health promotion team reached out to vulnerable patients and hard to reach groups, such as the homeless and those suffering from alcohol and drug dependency.
- Complaints were managed by the dental nurse manager in accordance with trust policy.
- The service had a very low level of complaints; the emphasis was on de-escalation and local resolution of problems.
- There were systems and processes in place to identify and plan for patient safety issues. This included potential staffing and clinic capacity issues.
- There was easy access for patients with a physical disability and wheel chairs could be accommodated on a specialist dental lift and tilt system. This meant wheelchair patients did not need to be transferred out of their chair.

However, we found that:

- The service did not provide treatment for patients under conscious sedation. Patients who were too nervous to have treatment without sedation therefore might

require a general anaesthetic in order to receive their treatment. However, we were told this service would be provided in August 2017, and we saw that one member of staff had been trained and was ready to start carrying out the procedure.

- The service received referrals for patients who did not meet the acceptance criterion. A process was in place to track and triage all referrals. However, this took administrative time and increased delays for some patients. We were told the service was working with local dentists to increase awareness of acceptance criterion.
- The waiting area had no facilities for children. There were no toys, books or anything to distract patients waiting.

### Planning and delivering services which meet peoples' needs

- Dental managers worked with other health and social care providers and commissioners to plan to meet the needs of patients in the area, particularly those with complex needs, long-term conditions, or life-limiting conditions. However, during this inspection the service was not providing treatment under conscious sedation. Conscious sedation allows patients to receive dental procedures which otherwise they may be too nervous to undergo. It involves a combination of medicines to help them relax and to block pain, and patients usually stay awake but may not be able to speak. Without conscious sedation, patients may only be able to receive the treatment through a general anaesthetic. A community dental services review carried out by NHS England (West Midlands) in March 2017, showed all other similar dental organisations in the region were providing this service. Managers told us that they have planned to restart providing conscious sedation in summer 2017, and that a member of their dental team has completed the required training.
- The needs of the local population were met by the provision of a flexible dental service that offered patients choice and provided continuity of care, particularly with the oral health promotion team and

## Are services responsive to people's needs?

mobile dental unit. The service reached out to patients within the community. However the service was not commissioned to provide an out of hours emergency service at weekends or evenings.

- Staff had a clear understanding of who their population group were and understood their needs including, making individual appointments sufficiently long to enable thorough investigations and treatment to be undertaken.
- Facilities and premises were appropriate for the services that were planned and delivered.
- If required, patients could be seen for short-term specialised treatment only, for example for some orthodontic treatments. On completion of short-term treatment, patients were discharged back to their own dentist for any ongoing care requirements.
- The service provided oral health care and dental treatment for children and adults that have impairment, disability and/or a complex medical condition and those who are nervous or dental phobic. Domiciliary dental services were provided where dental staff visited patients in their own home or a nursing home and a mobile dental unit provided care for children in specialist schools.
- There was an appointment system in place to respond to patients' needs. There were vacant appointment slots for the dentist to accommodate urgent or emergency appointments.
- Dentists had clinical freedom to adjust time slots to consider the complexities of the patient's medical, physical, psychological and social needs.
- In line with national guidance, dental treatment for patients requiring a general anaesthetic was carried out in a local hospital with critical care facilities.
- Domiciliary visits were provided for older patients living in residential care or their own homes. This service helped the trust to achieve its aim of treating patients closer to home. We did not observe these visits. We were told emergency cover was also provided for long stay hospital patients in the city of Coventry.
- There were systems and processes in place to identify and plan for patient safety issues in advance including any potential staffing and clinic capacity issues. This was facilitated by a 'daily huddle' system which the dental nurses undertook at the beginning of every day.

- Patients had access to a variety of information about their dental treatment in leaflet form. This information included pre and post-operative instructions and advice to help them manage their dental care effectively before, during and after any treatment received.
- There was adequate seating in the reception and waiting area. The treatment rooms had extra chairs for carers to sit on during treatment.
- Parking was available for patients at the health centre.

### Equality and diversity

- The service was planned to take into account the needs of different groups of patients who might want to use the service. For example different age groups and patients with different disabilities and we were told that it did not discriminate on any grounds including age, disability, gender, maternity status, race, religion or belief and sexual orientation. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.
- We noted that there were no facilities specifically for children in the waiting area.
- Reasonable adjustments were made so that patients with a disability could access and use the service on an equal basis to others.
- Steps were taken to ensure each patient, both children and adults, were treated as individuals, with their needs, preferences and their ethnicity, language, religious and cultural backgrounds being respected.
- The service was 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 with the average time for appointments being 45 minutes.
- The service had also considered the needs of patients with mobility issues. The premises had appropriate wheelchair access for patients with limited mobility and had disabled toilet facilities. Disabled access car parking was available at the health centre.
- The training records indicated that all staff received regular update training in equality, diversity and human rights.
- The service could deliver safe care to patients who were wheelchair users with a special wheelchair tipper device. This enabled patients to be treated in the supine position in the same way as physically able patients.

## Are services responsive to people's needs?

- Translation services were available for those patients whose first language was not English. However, there was no dental information leaflets available which was written in other languages.

### Meeting the needs of people in vulnerable circumstances

- The service was primarily a referral based specialised service providing continuing care to a targeted group of patients with additional needs due to physical, mental, social and medical impairment.
- Staff described to us how they had supported patients with additional needs, such as a learning disability. They ensured that patients were supported by their carer or a relative and that there was sufficient time to explain fully the care and treatment they were providing in a way that patients understood.
- Community dental services provided care to patients with special needs which general dental practices were unable to accommodate. These patients remained with the service long term and received regular dental surveillance, assessment and treatment as required.
- A mobile dental unit visited local special schools on a regular basis. This allowed patients to be treated where they were and avoided the need for potential complex travel arrangements in order to get to the health centre. This service prevented these groups of children from being forgotten in relation to maintaining their oral health care as they passed through adolescence and into adult services.
- Staff explained how they helped to support patients living with dementia and some staff had accessed additional training in dementia care in order to understand the condition and how to help patients more effectively.
- Vulnerable patients were flagged on the waiting list. This ensured they were followed up more rigorously if they missed an appointment.
- An oral health education team was available to support the dentistry service. This enabled treatment to be backed up by preventative education from the oral health educators in the patients' own homes and schools with their parents or carers.
- The oral health education team reached out to vulnerable groups including the homeless and those with drug and alcohol dependence.
- The service was able to accommodate patients in wheelchairs or who needed specialist equipment. There

was sufficient space to manoeuvre and position a patient using a wheelchair in a safe and sociable manner. Preventative dental information was given during consultations in order to improve the outcomes for patients. This included dietary advice and general dental hygiene procedures such as brushing techniques and recommended tooth care products.

- Patients were provided with information about the services offered on the waiting room notice boards. There were also a number of leaflets describing the range of treatments which were available and their costs outlined. There were leaflets for specific treatments, such as root canal, and oral hygiene.
- The waiting room area was large enough to accommodate pushchairs and wheelchairs. However, there were no facilities specifically for children in the waiting area. For example, there were no toys or books which could be used to distract nervous children.

### Access to the right care at the right time

- The dental service was open Monday to Thursday from 9.05am to 4.30pm and from 8.50am to 4pm on Friday. There were no services offered outside of these hours. However, there was an answer machine message giving details of where emergency dental help could be obtained.
- The number of appointments the dental service carried out had increased since the previous year. From April 2016 to March 2017, the total number of all appointments was 11,343, compared with 3,162 appointments for the six months ending February 2016. In the month of February 2017, there were 968 appointments, compared with 591 in February 2016.
- During our 2016 inspection, we found there were excessive waiting lists and that over 400 vulnerable adults and children were waiting for their first assessment appointment. We told the trust it must develop a strategy to effectively manage its dental waiting list and that it must develop a criterion for assessing the risk of harm to those patients waiting excessive lengths of time. From April to July 2016, the waiting list was reduced from 400 patients to 179 patients. Of these, 71 patients were waiting for a general anaesthetic (GA) appointment and the longest wait for this had been reduced from 10 months, to six months. There were 78 patients waiting for routine special care and their longest wait in July 2016 had been reduced from 12 months to eight and a half months. In May 2017,

## Are services responsive to people's needs?

the waiting time for a GA assessment was 10 weeks and the waiting time for a routine appointment was 18 weeks. At the time of our inspection in June 2017, we were told there were eight patients waiting for a GA appointment and four patients waiting for a routine appointment. Waiting lists had been added to the service risk register and a dental nurse had been appointed to oversee and manage this list.

- Information regarding the opening hours was available on site. There was an answer phone message which provided information about opening hours as well as how to access out of hours treatment from other providers. Some emergency appointments were kept free each day so the service could respond to patients in pain. Patients unable to access the services were visited in their own homes, care homes or nursing homes.
- Staff told us they had very low cancellation rates and the 'did not attend' (DNA) rate was 8%. Any DNA patient who did not contact the service was referred back to their general dentist.
- General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long-term continuing care to the community dental service. The service and commissioners had developed a set of acceptance and discharge criteria so that only the most appropriate patients were seen by the service. On completion of treatment, dentists discharged the patient back to their own dentist to resume ongoing care. Dentists sent discharge letters to the referring practitioner following completion of treatment.
- Protocols were in place to discharge patients following a GA. We did not observe a GA procedure during our inspection. However, staff told us about the safe discharge process which they adhered to, including both written and verbal post-operative instructions.
- During our inspection, appointments were running to time and patients waiting told us that they had not

experienced any delays previously. Staff told us if delays became apparent, they would explain this to the patients waiting and if necessary offer to rebook appointments if patients did not want to wait any longer.

- Patients in the city of Coventry who were inpatients in hospitals operated by Coventry and Warwickshire Partnership NHS Trust could access urgent emergency dental care through this service. Follow-up treatment was provided by the patient's own dentist or assistance provided to the patient to find a local dentist for continuing treatment.

### Learning from complaints and concerns

- No formal complaints had been reported from February 2016 to January 2017 regarding dental services. Informal complaints were handled by staff at the time wherever possible or directed to the Patient Advisory Liaison Service and to the Friends and Family information leaflets.
- The dental nurse manager logged and managed all complaints. We were told each one, both formal and informal, was discussed at staff meetings to allow learning and reflection to take place. We saw meeting minutes, which confirmed this had taken place.
- Staff told us about how they handled informal complaints and how they used them to improve their service. For example, a patient arrived early for an appointment which was then delayed due to unforeseen circumstances. Staff did not advise the patient at the time about the unexpected delay. Learning from this incident meant that staff now actively locate patients in the waiting area and inform them of any delays.
- Information on how to complain was accessible on the trust website and also throughout the service. Details were provided telling patients how to raise a complaint about the care they had received.

## 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.

We rated the service as good for well-led because:

- The service was led by a clinical lead and a head of planned care.
- The clinical director maintained overall responsibility and accountability for the running of the service.
- A dental nurse manager was responsible for the day-to-day running of the service and provided support to the clinical director.
- The local management team was visible and accessible to staff and the culture was open and transparent.
- Governance systems and risk management structures were in place which ensured action plans had been developed for most identified risks.
- Staff members we spoke with told us the service was a good place to work and that they would recommend it to family members or friends.
- The staff we spoke with said they felt well supported by the clinical lead and the dental nurse manager. Staff told us they could raise any concerns and were confident that these would be addressed and dealt with in a timely manner.
- The culture of the service was one of continuous learning and there was a drive to improve standards.
- Staff said they had been involved in the new and developing strategy for dental services.

However, we found that:

- Not all risks had oversight by a senior member of the clinical team. This included the completion of actions following a legionella risk assessment and the adequacy of water safety, including water temperature monitoring in the dentistry clinics.
- The newly developed dental strategy was not fully operational and it relied on a dental plan which was incomplete. However, staff told us the plan was a work in progress and that it would be completed, although no dates had been set.
- Inappropriate referrals into the service continued to use resources and cause delays for some patients. Although inappropriate referrals had been reduced since our 2016 inspection, the problem remained and required ongoing work which impacted on the efficiency of the service.

### Leadership of this service

- The service was led by a clinical lead and a head of planned care. The clinical lead was due to retire from the service in summer 2017. A new permanent clinical lead was appointed. The permanent clinical director was on maternity leave at the time of our inspection.
- The clinical director maintained overall responsibility and accountability for the running of the service. The clinical director fostered a culture of accountability by devolving responsibility to other appropriate individuals within the service.
- A dental nurse manager was responsible for the day-to-day running of the service and provided support for the clinical director. Senior dental staff told us that the dental nurse manager was a strong and visible leader who ensured the dental service ran effectively.
- The dental management team were responsible for passing information upwards to the trust managers and downwards to the clinicians and dental nurses on the front line. The structure in place appeared to be effective and was confirmed when we spoke to various members of staff and reviewed staff meeting minutes.
- The dental management team were responsible for the safe implementation of policies and procedures in relation to infection control, dealing with medical emergencies and incident reporting.
- Staff confirmed that they felt valued in their roles within the service and the local management team were approachable, supportive and visible at all times.
- We found the relationship between the staff and the local management team was good and staff at all levels reported there was an open door policy. The staff we spoke with said they felt well supported by the clinical director and the dental nurse manager. They said that they could raise any concerns and were confident that their concerns would be addressed and dealt with in a timely manner.
- Staff members we spoke with told us the service was a good place to work and that they would recommend it to family members or friends.

## Are services well-led?

- The culture of the service was one of continuous learning and there was a drive to improve standards of care in new innovative ways.

### Service vision and strategy

- The vision of the service was to improve the oral health of all patients accessing their services and to promote good dental hygiene to the population of the city of Coventry. The strategy was documented as:
  - To improve the quality and safety of services in a challenging environment, underpinned by trust values;
  - Continue to be the leading provider of local specialist orthodontic care, special care dentistry and oral health promotion in Coventry;
  - Maximise efficiency and reduce cost so that they remain a high value organisation;
  - Become a paper-light organisation with access to IT at the chairside;
  - Maintain communication with general dental practitioners in Coventry.
- There was an evolving strategy which dental staff were aware of and had been involved in developing. We saw that a plan had been developed in order to fully implement the new service strategy. However, at the time of our inspection, the plan was not fully operational and all actions had not been completed and many had not been assigned.
- Dental staff we spoke with said the service had a forward thinking and proactive clinical lead that was well supported by senior managers within the trust.

### Governance, risk management and quality measurement

- There was a governance framework in place which included regular meetings attended by staff of all grades and professions. We saw minutes of these meetings which were well attended and where risk and quality assurance was discussed.
- The governance systems and risk management structures in place ensured action plans had been developed for most of the identified risks. However, we found not all risks had oversight by a senior member of the clinical team. This included the governance around the management and reporting of safe water systems. We were told that water safety was the responsibility of the landlord of the building and that the dentistry service relied on them to meet the national guidance on

the control of legionella. Managers could not provide the evidence that showed their water had been checked and was safe. We were therefore not assured that their governance system was sufficiently robust in this area.

- During our 2016 inspection, we were told that the dental service did not have its own defined risk register and that its risks were recorded on the local integrated community services risk register. However, we found that the dental service had not recorded any local risks on this register. During this inspection, we found that a risk register had been developed and actions to address issues had commenced. Staff confirmed they were aware of these risks.
- There were monthly staff meetings at departmental level where concerns and service delivery issues were discussed. Feedback from patients was regularly discussed along with updates on actions from the risk register. Staff attended these meetings regularly which helped to ensure they were fully involved with improving the service.

### Culture within this service

- The acting clinical lead was due to retire in summer 2017. A new substantive clinical lead had been appointed but was on maternity leave at the time of our inspection. The acting clinical lead told us the culture within the service was being taken a step forward as a result of findings from our 2016 inspection report, and that staff were now inspired to strive for continued improvements. We were told staff were open to new ideas, willing to change and were able to question practice within their teams and suggest new ways of working.
- During our 2016 inspection, we reported that the service was in a period of transition following the retirement of some longstanding personnel and that morale was lower than usual. During this inspection, we found a very positive culture with a high level of staff engagement. We observed that staff were very passionate about working within the service and proud to be providing good quality care for their patients. Staff spoke about their work and conveyed their dedication to what they did.
- The culture of the service included continuous learning and developing both for individual staff and for the service as a whole. Staff worked well together as a team and respected each member's individual contribution.

## Are services well-led?

- Staff had a 'can do' philosophy about their practice and the challenges they faced. There was a happy and calm working environment which was positive for patient care.
- Staff were aware of the whistleblowing policy on raising concerns about the service, including the performance of other staff, and said they would feel confident in accessing the process if necessary.

### Public engagement

- Friends and Family Test feedback forms were available for patients in the waiting area and feedback was used to help inform service plans and improvements. Feedback was generally very positive. For example, one patient reported they were 'really pleased and happy' with their dental treatment.
- The service had recently started engaging with the public through social media, such as Facebook and Twitter. Staff regularly used social media to promote dental health and to provide advice and information.

### Staff engagement

- Senior managers told us staff engagement had improved following our 2016 inspection. Staff we spoke to said they felt included in the organisation and that they wanted to be part of its future plans.
- A values based appraisals process was in place which included a mandatory section on staff wellbeing. This encouraged discussion and was an opportunity to identify further support.
- Staff told us of the various ways the trust engaged with them including newsletters, team brief and via 'all staff' group emails.
- The service gathered feedback from staff through meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

- Meetings were held monthly which all staff could attend. Staff told us they all played an equal part in these meetings and could contribute to all of the discussions. Staff told us visiting educators from other dentistry services and product suppliers would often attend these meetings and provide clinical updates.

### Innovation, improvement and sustainability

- The department aimed to improve its service with the introduction of conscious sedation. This service was planned to start in summer 2017.
- A part of the service strategy was to increase the use of electronic patient records and to become a paper light organisation. At the time of our inspection, this work was well underway but no date for completion was provided.
- The service continued to work with the Public Health England and to carry out epidemiology surveys when required. Epidemiology surveys look at the health of a group of patients and the results help to inform the planning of future services.
- The service planned to increase its sustainability by becoming more efficient and reducing costs. To help with this, it was investigating setting up its own decontamination unit for the sterilisation of dental instruments and also replacing its mobile dental unit. At the time of our inspection, these plans had not been agreed.
- Staff were given access to extra training and to take further qualifications to enhance the patient experience and improve the services offered. This included further training for a dental nurse to work as an orthodontic dental therapist.
- The dental service had started discussions with dental training schools with a view to supporting trainee dental nurses and student dental nurses, a process which they had previously not been involved with.