DHSC – CQC external quality regulation programme

Central Community Health Centre
Community Dental Service

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Douglas

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https://www.gov.im/categories/health-and-wellbeing/dentists/community-dental-service/

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Our findings

Overall summary

We carried out this announced assessment on 12 July 2022. The assessment was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

The CQC does not have statutory powers with regard to improvement action for services on the Isle of Man, and services on the island are not subject to CQC's enforcement powers. This assessment is one of a programme of assessments that the CQC is completing at the invitation of the Isle of Man Government's Department of Health and Social Care (IOMDHSC) in order to develop an ongoing approach to providing an independent regime of health and social care services delivered or commissioned by IOMDHSC and Manx Care. To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions form the framework for the areas we look at during the assessment.

Our key findings were:

- The service appeared to be visibly clean and well-maintained.

- The service had infection control procedures which did not fully reflected published guidance.
- Staff knew how to deal with emergencies. Medicines and life-saving equipment were available but did not fully reflect published guidance.
- Systems to help them manage risk to patients and staff could be improved.
- The service had safeguarding processes which could be improved upon. In-person, face to face Safeguarding training was not currently available to staff.
- Staff told us there were appropriate recruitment procedures in place, staff recruitment records were not available to confirm this.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff told us they were unable to complete core service delivery due to daily increase in emergency pain patients.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs. The delivery of routine and specialist care was being limited due to workload pressures.
- The service provided a domiciliary and sedation service; however, this was compromised due to circumstances beyond the control of the service.
- Effective leadership, management and clinical oversight could be improved.
- There was a culture of continuous improvement, we identified minor adjustments could be made to improve learning.
- Staff stated they felt respected, supported and valued but they were also feeling the workload impact, despite these challenges, they remained focussed on delivery.
- The service asked staff and patients for feedback about the services they provided.
- The service dealt with complaints positively and efficiently.
- The service had information governance arrangements.

We found areas where the service could make improvements. CQC recommends that the service:

- Improve the service infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Take action to ensure audits of radiography and infection prevention and control are undertaken at regular intervals to improve the quality of the service. The service should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

- Improve the service systems for checking and monitoring equipment taking into account relevant guidance and ensure that all equipment is well maintained.
- Take action to ensure ongoing fire safety management is effective.
- Review the service protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2019 and Ionising Radiation (Medical Exposure) Regulations 2019 and taking into account the guidance PHE-CRCE-023 on the safe use of Hand-held Dental X-ray Equipment.
- Implement protocols and procedures to ensure staff are up to date with Manx mandatory training and their continuing professional development.
- Improve the service sharps procedures to ensure compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Take action to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases, taking account of guidance issued for healthcare professionals on immunisation: Immunisation of healthcare and laboratory staff: the green book, chapter 12. Take action to ensure the availability of equipment in the service to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.
- Improve the service processes for the control and storage of substances hazardous to health identified by the Control of Substances Hazardous to Health Regulations 2002, to ensure risk assessments are undertaken and the products are stored securely.
- Improve the security of NHS prescription pads and ensure there are systems in place to track and monitor their use.
- Implement protocols for domiciliary visits taking into account the 2009 guidelines published by British Society for Disability and Oral Health in the document “Guidelines for the Delivery of a Domiciliary Oral Healthcare Service”.
- Improve and develop staff awareness of the legal framework for acting and making decisions on behalf of adults who lack capacity to make decisions for themselves, including decisions on whether a child is able to consent to their own medical treatment, without the need for parental permission or knowledge.
- Implement protocols and procedures in relation to, for example, the Accessible Information Standard, which aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services.
- Implement protocols and procedures in relation to, for example, the Accessible Information Standard to ensure that that the requirements are complied with.
- Improve the practice's risk management systems for monitoring and mitigating the various risks arising.
- Improve the practice’s arrangements for ensuring good governance and leadership are sustained in the longer term.

We have also identified areas we have escalated to the IOMDHSC.

- Implement amalgam waste handling protocols to ensure amalgam waste is disposed of, in compliance with the relevant regulations and take into account the guidance issued in the Health Technical Memorandum 07-01.
- Review the need to undertake a Legionella risk assessment, taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance.
- Take action to ensure that all staff have received appropriate safeguarding training and are aware of the scope of and referral pathways for safeguarding of children and vulnerable adults.

Background to assessment

The Central Community Health Centre, Community Dental Service is in Douglas and provides NHS special care dentistry and emergency dental services and treatment for adults and children. Services include referrals for mental health and dental phobic patients, vulnerable adults and children. Sedation, patients with complex medical health and prison and domiciliary services.

There is level access to the service for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice.

The dental team includes five dentists, 14 dental nurses, a decontamination technician, two administrative assistants, one executive officer and one administrative officer. The service has nine treatment rooms.

The service is open:

Monday to Thursday 8:30am – 4:30pm and Friday 8:30am – 4pm.

On the day of assessment, we spoke with one patient, four dentists, five dental nurses and the administrative officer. We looked at policies and procedures and other records about how the service is managed.

You can find information about how we carry out our assessments on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

We found this service was not always providing safe care in accordance with CQC's assessment framework.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had systems to keep patients safe, some of these systems could be improved upon.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The service had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We were told Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

We identified the following areas could be improved upon to align with current policy:

- Support staff had not received safeguarding training at a level relevant to their role. In-person, face to face Safeguarding training was not currently available to staff.
- Not all staff were aware of the reporting protocol i.e. reporting to the lead Safeguarding person.
- Safeguarding concerns and relevant information was not comprehensively recorded for future reference purposes.

The service had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The service also had a system to identify adults that were in other vulnerable situations. For example: those who were known to have experienced modern-day slavery or female genital mutilation.

The service had an infection prevention and control policy and procedures.

Staff completed infection prevention and control training and received updates as required.

The service arrangements for transporting, cleaning, checking, sterilising and storing instruments was not conducted in line with published guidance, namely HTM 01-05 Decontamination in primary care dental practice, for example:

- Staff used the ultrasonic bath in addition to manually cleaning the dental instruments
- Water temperature was not monitored during the instrument cleaning process
- Limited personal protective equipment was used during instrument decontamination process
- Staff did not use protective heavy-duty gloves when cleaning instruments
- A bur brush was used to remove debris from instruments

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the service that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of injury from a sharp instrument.

Records showed that the equipment used by staff for cleaning and sterilising instruments was not validated, maintained and used in line with the manufacturers' guidance.
The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

The service did not have adequate procedures in place to reduce the risk of Legionella or other bacteria developing in water systems. A Legionella management risk assessment had not been undertaken.
Records did not show that regular water testing and dental unit water line management was being carried out. In addition, we noted that dental unit water line management was not in place for the two unused treatment rooms in the service.

We saw effective cleaning schedules to ensure the service was kept clean. When we carried out our assessment, we saw the service was visibly clean.

Except for the removal of amalgam waste, the service had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The service carried out infection prevention and control audits, these did not accurately reflect the instrument decontamination process we observed during out visit. We discussed the inclusion of learning points and action plans to the audit process to ensure continuous improvement.

The service had a Speak-Up policy and support staff felt confident they could raise concerns internally without fear of recrimination.

Delivery of service concerns and decreasing staffing levels had been escalated upwards within the chain of command. We were told the service was awaiting an outcome.

The dentists used dental dams in line with appropriate guidance when providing root canal treatment to patients. In instances where a dental dam was not used, for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

Staff told us the administration for recruiting new staff was the responsibility of the Human Resource department. No staff recruitment records were held on-site. We were unable to confirm if staff were effectively recruited in line with current policies and procedures. Records were not

made available to us to confirm clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover. We were told retrospectively these records were held within the department.

Improvements could be made to ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, for example:

- The portable appliance testing was overdue
- Current maintenance certification for the autoclaves was not available for review
- A current pressure vessel testing certificate was not available for review
- The 5-year fixed wiring certification for the service was completed in 2019, however the service was unaware that this had taken place and if the recommendations listed had been completed
- We noted the security of an external door and the staff rest area could be improved to prevent unauthorised access

An in-house fire risk assessment was in place. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. We noted there was no in-house fire safety checks for the fire extinguishers to ensure they were fit for purpose if ever needed in an emergency.

The service had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

The service used a hand-held X-ray machine. We were told this machine was stored in a locked treatment room when not in use and the battery was removed. Staff had received training in the use of it and appropriate safeguards were in place for patients and staff. We discussed seeking advice of the Radiation Protection Advisor to discuss the requirements for using personal dosimeters when using the hand-held X-ray machine and the requirement to arrange annual rather than bi-annual servicing of this machine.

We were shown evidence the dentists justified, graded and reported on the radiographs they took.

The service carried out radiography audits every year following current guidance and legislation. We discussed the inclusion of learning points and action plans to the audit process to ensure continuous improvement.

We saw systems were in place to record the clinicians continuing professional development in respect of dental radiography, however, not all staff were up to date.

Risks to patients

The service had not fully implemented systems to assess, monitor and manage risks to patient and staff safety. In particular relating to sharps safety, Hepatitis B immunity and medical emergencies.

The service had current employer's liability insurance.

We looked at the service's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles. A sharps risk assessment had not been undertaken to help them manage other sharp dental instruments.

There were systems in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus. There was no follow up process to ensure the effectiveness of the vaccination was checked.

Staff were aware of the signs and symptoms of Sepsis. This helped ensure staff made triage appointments effectively to manage patients who presented with a dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency. Systems were in place to record staff's basic life support training but not all staff were up to date. Records were available for Immediate Life Support training with airway management for staff providing treatment under sedation.

Emergency medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order. Not all emergency equipment was available as described in recognised guidance, for example:

- Three of the required five clear face masks were not in place
- The Ambubag was out of its packaging and we were unable to confirm if the item was latex free. (this is relevant if needed to be used on a patient with a latex allergy)

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team.

The service had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. These had not been reviewed or updated since 2016 and safety data sheets were not in place. We noted hazardous materials and pathology samples were being stored in an unsecured room.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentists how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to corroborate our findings and observed that individual records were typed and managed in a way which kept patients safe. Dental care records we saw were complete, legible, were kept securely.

The service had systems to treat patients with suspected oral cancer to help make sure they were seen quickly by a specialist.

Safe and appropriate use of medicines

We saw prescriptions were not stored securely or monitored as described in current guidance.

The dentists were aware of current guidance with regard to prescribing medicines. Antimicrobial prescribing audits were carried out annually. We discussed the inclusion of learning points and action plans to the audit process to ensure continuous improvement.

Track record on safety, and lessons learned and improvements

The service had implemented systems for reviewing and investigating when things went wrong.

Staff monitored and reviewed incidents. This helped staff to understand the potential risks and led to effective risk management systems as well as safety improvements.

Where there had been a safety incident, we saw these were investigated, documented and discussed with the rest of the dental team to prevent such occurrences happening again.

The service had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Is the service effective?

We found this service was not always providing effective care in accordance with CQC's assessment framework.

Effective needs assessment, care and treatment

During discussions with the clinical team we reviewed a selection of dental care records. The dental care records we reviewed showed there has been a significant number of on-the-day pain patients increasing. We were told patients who needed immediate pain relief but were unable to be offered one of the allocated daily emergency appointment slots would sit and wait to be seen. The impact of this has meant the capacity to deliver the core service of special care dentistry has been significantly compromised.

The service was currently unable to deliver adult and paediatric general anaesthetic procedures provided at Noble's Hospital, intravenous sedation services were currently on hold and domiciliary services to the community and prison service have been reduced due to circumstances beyond their control.

The service had systems to keep dental professionals up to date with current evidence-based practice. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Though currently on hold, the service offered intravenous sedation for patients. This included patients who were very anxious about dental treatment and those who needed complex or lengthy treatment. The service had systems to help them do this safely. We were told inhalation sedation treatment was available for patients within the service.

The service systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The staff assessed patients for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history; blood pressure checks and an assessment of health using the guidance.

The records showed staff recorded important checks at regular intervals. These included pulse, blood pressure, breathing rates and the oxygen content of the blood.

The service provided a domiciliary dental provision in settings such as prison services, care homes and in people's residence. Some of these services has been reduced due to circumstances beyond their control. We discussed areas where we found improvements could be made, for example:

- Medical oxygen was not currently considered, risk assessed or taken on any domiciliary visit
- A risk assessment was not completed prior to undertaking a domiciliary visit
- Regular dental unit water line management, and the flushing of taps in respect to legionella contamination prevention was not consistent in the prison setting. We were told there was no guarantee of a weekly visit to the prison as these were often cancelled.

Helping patients to live healthier lives

The service provided preventive care and supported patients to ensure better oral health.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The service had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and completing detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The dental team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The clinical team understood their responsibilities when treating adults who might not be able to make informed decisions, and that children under 18 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people.

We discussed the support staff's awareness of the legal framework for acting and making decisions on behalf of adults who lack capacity to make decisions for themselves, including decisions on whether a child is able to consent to their own medical treatment, without the need for parental permission or knowledge. It was agreed that due to limited awareness in some area's refresher training would be beneficial.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The service kept detailed dental care records containing information about the patient's current dental needs, past treatment and medical history. The dentists assessed patient's treatment needs in line with recognised guidance.

The service had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits. We discussed the inclusion of learning points and action plans to the audit process to ensure continuous improvement.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the service had a structured induction programme. Systems were in place to ensure clinical staff completed the continuing professional development required for their registration with the General Dental Council, however, we noted some staff were not up-to date.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The service was a referral hub for dental phobic and mental health patients, vulnerable adults and children. Patients with complex medical history, sedation, prison and domiciliary services.

Is the service caring?

We found this service was providing caring services in accordance with CQC's assessment framework.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights. We saw staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, the service would respond appropriately. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

- Interpreter services were available locally for patients who did not speak or understand English.

- We discussed having access to, for example, the Accessible Information Standard, an NHS initiative, which aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Staff gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The service website provided patients with information about the range of treatments available.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, study models and X-ray images.

Is the service responsive?

We found this service was not always providing responsive care in accordance with CQC's assessment framework.

Responding to and meeting people's needs

The service had adjusted their treatment delivery to meet patients' needs. For example, to accommodate patients who were not registered with a general dental practice on the Isle of Man. We were told, this had impacted on the delivery of the specialist community dental services.

Staff were clear about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

Patients described high levels of satisfaction with the responsive service provided by the practice. We were able to talk to one patient on the day of assessment.

The service currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The service had made reasonable adjustments to support disabled patients. This included step free access, a hearing loop, a magnifying glass and an accessible toilet with handrails and a call bell, wheelchair adaptable dental chairs and large ground floor treatment rooms.

Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

Patients could access care and treatment from the service within an acceptable timescale for their needs, however, the capacity to deliver the core Service was being significantly compromised due to staffing pressures and the number of emergency pain appointments increasing daily.

The service displayed its opening hours in the premises and included it on their website.

The service had an appointment system to respond to patients' current needs. Patients who requested an urgent appointment were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the assessment and patients were not kept waiting.

The service's website, email and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the service was closed.

The service directed patients to MEDS (Manx Emergency Doctors Service) between 6pm – 8am and the Emergency Dental Service between 9am -11am weekends and bank holidays.

Listening and learning from concerns and complaints

Staff told us the service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The service had a policy providing guidance to staff about how to handle a complaint. The service information leaflet explained how to make a complaint.

The complaints and incident manager for Primary and Community Care was responsible for handling complaints.

Where possible the service aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the service had dealt with their concerns.

We looked at comments, compliments and complaints the service had received in the last 12 months. These showed the service responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Is the service well-led?

We found this service was not always providing well-led care in accordance with CQC's assessment framework.

Leadership capacity and capability

We were told, that due to there being a gapped clinical director post, there was limited management and clinical oversight in place, which had led to a service provision with no direction or strategic plan.

The clinical team had the values and skills to deliver high-quality, sustainable care, we found this was being challenged on a daily basis due to factors beyond their control. The capacity to deliver the core service was being significantly compromised due to staffing pressures and the number of emergency pain appointments increasing daily.

The service no longer had clinical directorship, leading to limited clinical oversight and direction.

Clinical staffing pressures have led to targets and delivery of care being under significant strain. Staff were showing signs of stress and low morale.

The clinical team raised their concerns with us during our visit. CQC escalated these concerns to Manx Care within 12 hours in line with the Service Level Agreement.

Culture

The service had a culture of high-quality sustainable care. This was at risk and specialist services were being impacted.

Staff stated they felt respected, supported and valued but they were also feeling the workload impact.

Pressures on the overall delivery of the service had meant they had to pause some routine administration, such as regular staff meetings and staff appraisal.

The staff focused on the needs of patients. We were told, despite the workload burden the team was experiencing they remained focussed to deliver the dental service to the best of their ability.

Support staff could raise concerns internally. Delivery of Service concerns and decreasing staffing levels had been escalated upwards within the chain of command.

We saw the service had systems in place to deal with staff poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints.

Governance and management

Staff responsibilities, roles and systems of accountability to support good governance and management were in place, however, staff were burdened with additional responsibilities which had led to some systems being unmonitored, streamlined or paused.

The service no longer had a clinical director in place. Clinical responsibility for the management and clinical leadership of the practice was currently being overseen by the clinical lead dentist.

The executive officer was responsible for the day to day running of the service.

The service had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff.

We identified some systems and processes for managing risks, issues and performance could be improved upon. For example:

- Safeguarding awareness, training and record keeping
- Infection prevention and control systems and processes
- Legionella risk management and oversight
- Quality assurance and audit
- Oversight of facilities and equipment maintenance
- Fire safety management
- Radiation safety in respect to the hand-held equipment
- Safer sharps risk management systems
- Oversight of immunity levels for vaccine preventable infectious diseases.
- Oversight of medical emergency systems and processes
- COSHH management
- Prescription security and tracking
- Domiciliary services systems and processes
- Oversight of continuing professional development, MCA and Gillick
- Clinical oversight, management and governance systems

Appropriate and accurate information

The service had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff involved patients, the public, staff and external partners to support the service. The team used patient surveys, comment cards and encouraged verbal comments to obtain staff and patients' views about the service.

Patients were encouraged to provide feedback about NHS services they have used. Feedback was collated by the Complaints and Incidents Manager.

Whilst some systems, such as staff meetings were currently paused, the service gathered feedback from staff through meetings, surveys, and informal discussions.

Continuous improvement and innovation

The service had systems and processes for learning, continuous improvement and innovation.

The service had quality assurance processes to encourage learning and continuous improvement.

These included audits of dental care records, infection prevention and control, radiographs and antimicrobial prescribing. Staff kept records of the results of these audits. We discussed the inclusion of learning points and action plans to the audit process to ensure continuous improvement.

The infection prevention and control audit did not accurately reflect what we saw in practise.

Improvements could be made to ensure all staff complete 'highly recommended' training as stated in the General Dental Council professional standards in a timely manner.

The service supported and encouraged staff to complete continuing professional development, the arrangement of some training elements, such as in-person, face to face Safeguarding for the entire team was beyond the control of the service.