# Condor Dental Centre

45 CDO RM, Arbroath, Angus, DD11 3SJ

## Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

| | | |
|---|---|---|
| Are services safe? | **No action required** | ✓ |
| Are services effective? | **No action required** | ✓ |
| Are services caring? | **No action required** | ✓ |
| Are services responsive? | **No action required** | ✓ |
| Are services well led? | **No action required** | ✓ |

# Contents

# Summary

## About this inspection

We carried out an announced comprehensive inspection of Condor Dental Centre on 18 April 2023 and sought patient feedback about the service by telephone on 8 March 2023.

**As a result of the inspection we found the practice was safe, effective, caring, responsive and well-led in accordance with the Care Quality Commission's (CQC) inspection framework.**

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

## Background to the practice

Co-located with the medical centre, Condor Dental Centre has 2 surgeries. The practice provides a routine, preventative and emergency dental service to a military patient population that can range between 450 and 650. At the time of the inspection, one of the surgeries was not being used to treat patients so was being used exclusively for the sterilisation of equipment.

The practice is open on a Monday from 12:30 to 17:00 hours, on Tuesdays and Thursdays from 08:00 to 12:30 hours and on Friday from 08:00 to 12:30 hours. Emergency appointments are available each working day. Patients could access NHS 24 for a dental service out-of-hours.

### The staff team

| | |
|---|---|
| Dentist | Senior Dental Officer (military) |
| Dental nurses | One military – currently deployed<br>One civilian – recruitment in progress |
| Practice manager | Military |

## Our Inspection Team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and hygienist/practice manager specialist advisor.

## How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the Senior Dental Officer, practice manager and a dental nurse from Neptune Dental Centre who was temporarily supporting the practice. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We checked the building, equipment and facilities. We also reviewed patient feedback and interviewed patients who were registered at the dental centre.

**At this inspection we found:**

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Leadership at the practice was inclusive and the team worked well together.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Systems were in place to support the governance and risk management of the practice.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Staff were up-to-date with appraisals, required training and continuing professional development.
- The Senior Dental Officer provided care and treatment in line with current guidelines.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Processes for assessing, monitoring and improving the quality of the service were in place.
- Arrangements were in place to support the safe use of X-ray equipment.

**The Chief Inspector recommends to the practice:**

Review the process for monitoring prescription use to ensure that all prescriptions are accounted for.

**Mr Robert Middlefell BDs**

**CQC's National Professional Advisor for Dentistry and Oral Health**

# Our Findings

## Are Services Safe?

### Reporting, learning and improvement from incidents

All staff had a log-in to the Automated Significant Event Reporting (ASER) DMS-wide system to report incidents and significant events. Staff were up-to-date with training in using the system. Any incidents which impacted the delivery to patient care were reported through the ASER system and recorded on the ASER register. No significant events had been raised in the last 12 months. We were advised that the reduction in the use of ASER was due to accidents and near misses now being reported via the Defence Unified Reporting and Lessons System (referred to as DURALS) system, and any failure to capture from the digital radiograph system were reported on a separate spreadsheet.

Staff had a good understanding of the types of incidents that met the criteria for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (referred to as RIDDOR). Such incidents were reported through the ASER system.

Incidents and significant events were discussed with the team at the weekly practice meetings. They were documented in the minutes, which all staff had access to via the practice SharePoint page.

The practice manager was the lead for managing alerts from the Department of Health Central Alerting System (CAS). There was a link on the SharePoint page so all staff could access CAS alerts. In addition, alerts were emailed out to staff and a hard copy held in the office, which all staff were required to sign to indicate they had read.

### Reliable safety systems and processes (including safeguarding)

The regional Principal Dental Officer was the safeguarding lead and the Senior Dental Officer (SDO) the deputy lead for the practice. The SDO had completed level 3 safeguarding training. In the absence of the SDO, the team had access to the safeguarding lead in the medical centre. All members of the staff team were up-to-date with safeguarding training at a level appropriate to their role. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances.

Reviewed in August 2022 and displayed on the notice board, the practice safeguarding policy included the contact details for reporting a safeguarding concern. No patients under the age of 18 were registered with the practice at the time of the inspection. The SDO advised us that the Unit Personnel Officer would inform the practice if any new joiners were under the age of 18. In addition, the SDO carried out regular searches to check if any under 18s had registered as a patient. The practice manager attended the quarterly unit meetings at which the patient population was discussed and, if appropriate, they would be made aware of any vulnerable patients.

The SDO was aware of the duty of candour principles; a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The duty of candour principles were displayed.

The SDO was always supported by a dental nurse when treating patients. A chaperone policy was in place. The practice had a good relationship with the medical centre team whom they could call on for additional support if needed. Lone working rarely took place and there was a process in place for the last person leaving the building to sign. The dental centre keys were returned to the guard room when the practice was closed. Buildings were thoroughly checked during regular security rounds by the unit.

The SDO routinely used rubber dam in line with guidance from the British Endodontic Society for all root canal treatment, confirmed by a review of patient records.

The business continuity plan (BCP) was revised in September 2022 and outlined how the service would be provided if an event occurred that impacted its operation. The BCP had been activated when the compressor failed and also when the practice had been short of staff.

### Medical emergencies

Reviewed in September 2022, the medical emergency procedure was displayed on the notice board. In addition, a British Dental Association table outlining the types of medical emergencies was displayed, including signs/symptoms and how to manage each event. The medical emergency kit including the automated external defibrillator (AED), medicines and oxygen were checked on the days the practice was open. The kit was held in a central location so was easily accessible if needed. It was secured in a locked room when the practice was closed. Records showed staff were up-to-date with training in managing medical emergencies including annual basic life support, the use of the AED and anaphylaxis. The nominated first aider was current with Level 2 first aid training. Scenario based training in the management of an epileptic seizure had previously been undertaken. The SDO acknowledged that since taking up post there had been limited opportunities to complete further scenario-based training due to deployments of the staff team.

The first aid box was clearly signposted. The biohazard spill kit, first aid kit, eye care kit and mercury spillage kit were checked regularly to ensure they were in-date.

The team completed sepsis training in January 2023. The signs and symptoms of sepsis were displayed for quick reference.

### Staff recruitment

The practice manager had oversight of the recruitment of permanent and locum staff. The full range of recruitment records for permanent staff was held centrally. Evidence was in place to confirm that recruitment checks had been completed for staff new to the practice. These included a Protecting Vulnerable Groups (PVG/Disclosure Scotland) certificate to ensure they were suitable to work with vulnerable adults and young people. The registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role were also monitored.

## Monitoring health & safety and responding to risks

The practice manager for the medical centre was the building custodian. The SDO was the health and safety lead for the dental centre with the practice manager acting as the deputy lead. The practice manager had good links and effective communication with the Safety, Health, Environment and Fire Officer (referred to as SHEFO) for the camp. The role of the SHEFO was to ensure the dental centre complied with all health and safety requirements.

A risk register specific to the practice was held on the regional risk register with risks managed in accordance with the ‘4 Ts’ (transfer, tolerate, treat, terminate). A range of risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The 5-yearly fire risk assessment was undertaken in March 2023 and the practice was awaiting a copy of the report. Firefighting equipment was checked each month by the fire warden and the fire alarm was tested every Monday. All staff had participated in a fire evacuation drill, facilitated quarterly by the fire warden. A plan of the building was displayed indicating the fire exits and muster point.

Both the SDO and practice manager had oversight of the Control of Substances Hazardous to Health (COSHH). The practice manager had completed the COSHH assessor course. COSHH products were stored securely and were reviewed annually with the next review due in September 2023. Staff had access to paper copies of the COSHH risk assessments and to electronic versions via a SharePoint link. A COSHH inventory was displayed indicating the expiry date of each product. The contracted cleaner kept cleaning products in a locked cupboard and had access to the COSHH risk assessments held in the contract manager’s office.

A legionella risk assessment was carried out by the contractor in July 2022. In accordance with the legionella plan, the temperature of sentinel water outlets (first and last taps on the water distribution system) were checked monthly. These records were shared with the practice and held on SharePoint. Weekly water temperature testing was carried out and recorded. A legionella briefing was displayed and included guidance about management and control.

The dental nurse flushed the dental unit water lines (DUWL) for 2 minutes at the start of each session and for 30 seconds between each patient. A disinfectant solution specific for DUWL was used weekly. Although DPHC guidelines indicated quarterly usage, the practice opted to use it weekly due to the high turnover of staff at the dental centre. The main water lines were run for 2 minutes at the start of each new clinical session following a prolonged period of inactivity.

Measures were in place to minimise the spread of COVID-19, including a risk assessment updated in February 2023. Information about COVID-19 and hand washing guidance was displayed. Hand sanitiser was provided throughout the building and a sufficient stock of personal protective equipment was available.

The practice adhered to relevant safety laws when using needles and other sharp dental items. A sharps policy was available and sharps boxes in clinical areas were labelled, dated and used appropriately. The number of sharps bins were sufficient for the needs of the practice. The training log confirmed staff had received in-service training on how to manage sharps injuries.

### Infection control

The dental nurse who was deployed at the time of the inspection was the lead for infection prevention and control (IPC) and completed the required training in February 2023 for this specialist role. During their deployment the IPC lead had maintained communication with the practice and completed many aspects of the role, including elements of the IPC audit remotely and had participated in IPC meetings virtually. The IPC lead from Neptune Dental Centre has visited the practice and advised the team on some improvements.

Staff were up-to-date with IPC training. A copy of the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) was available and the decontamination flowchart was displayed. An IPC audit was undertaken in April 2023 and showed overall an overall compliance of 83.73%. An IPC workbook was in place and included a summary of checks and an implementation plan. Many actions were dependent on infrastructure improvements.

The spare dental surgery was being used as a central sterile services department (CSSD). Clean and dirty zones were clearly labelled. Instruments were taken from the clinical surgery to the CSSD via a labelled red dirty box and then placed into the decontamination solution for soaking. Following this, instruments were transferred to the ultrasonic bath for 6 minutes. They were then rinsed, visibly inspected using a magnifying light and placed in the steriliser. A manual sterilisation record log was maintained. The final stage involved the drying and bagging of instruments. Packaged instruments were stamped with an expiry date. The room had 3 windows to facilitate ventilation. Decontamination scored 66.25% on the IPC audit as the arrangements for decontamination were not fully compliant with HTM 01-05. Funding had been agreed for the installation of a new CSSD including a ventilation system. In addition, air conditioning was to be installed in the clinical areas. The work was due to start in the summer of 2023.

Environmental cleaning was carried out by a contractor and a contract was in place describing the cleaning arrangements for each area and frequency. Cleaning materials were stored appropriately. The floor mopping protocol was reviewed in August 2022 and displayed on the noticeboard. The practice manager carried out visual inspections of the environment and monitored the cleaning log signed by the cleaner. Deep cleaning was carried out when the practice was closed for long periods. The cleaning contract was continually reviewed by both the cleaning supervisor and manager. The practice manager had regular contact with the cleaning manager through weekly meetings and environmental checks; any issues were promptly resolved.

The practice had its own clinical waste bin, which was stored securely outside along with the clinical waste for the medical centre. The dental centre maintained a clinical waste log and all entries in the log were accurate. Waste transfer notes and copies of consignment notes were all in order. The incineration record and the report of the waste incinerated was retained. A pre-acceptance audit was completed in May 2022 and showed 100% compliance. Pharmaceutical waste was disposed of via the medical centre.

### Equipment and medicines

The SDO was the lead for equipment care and the practice manager was the deputy lead. The practice manager maintained a comprehensive spreadsheet illustrating how equipment was managed, including ongoing maintenance. The spreadsheet included links to any required registers and reports from works carried out. All equipment testing/servicing was up-to-date, including equipment overseen by the Medical Device Safety Service (referred to as MDSS). Annual testing of the steriliser was next due in October 2023. A faults log was held on SharePoint.

Instruments and materials were regularly checked with arrangements in place to ensure materials were in date. The surgery was clean and tidy. All equipment held at the practice was latex free.

Stock was regularly monitored and orders for stock were managed remotely by the deployed dental nurse. No excessive stock was held as the practice. We checked the stock and it was all in-date. The ambient room temperature of the stock room was monitored and logged. Although the room had no climate control, there was the option to use another darker room should a cooler location be required. Medicines including emergency medicines were held securely. The pharmaceutical fridge temperature was checked twice a day and a record was maintained of the checks.

Prescriptions were stored securely in practice manager’s office. Although the SDO indicated prescribing was infrequent, a process was in place to monitor prescriptions issued. We noted gaps in the sequential numbering of prescriptions in the folder. There was also evidence of the destruction of incorrect prescriptions. Arrangements were in place for patients to collect prescriptions from a local nominated pharmacy.

### Radiography (X-rays)

Suitable arrangements were in place to ensure the safety of the X-ray equipment. The required information in relation to radiation was located in the radiation protection file. A Radiation Protection Advisor for the practice was identified. The SDO was identified as the Radiation Protection Supervisor (RPS). Due a recent deployment, the SDO had not yet completed the RPS training. They were on the waiting list and the course requirement was known to Regional Headquarters. Signed and dated Local Rules were displayed in the surgery along with safety procedures for radiography. X-ray equipment was maintained in line with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). Staff requiring IR(ME)R training had received relevant updates.

The clinical records we reviewed showed X-rays were quality assured. The SDO justified, graded and reported in the patient’s record the outcome of the X-rays they took. We discussed with the SDO future grading in line with the new guidelines. A quality assurance radiology audit was completed annually with the most recent one completed in May 2022. A new audit was started in April 2023.

# Are Services Effective?

### Monitoring and improving outcomes for patients

Our review of patient records demonstrated the treatment needs of patients was assessed in line with recognised national guidance, such as The National Institute for Health and Care Excellence. Equally, records showed the Senior Dental Officer (SDO) followed guidance from the British Periodontal Society regarding periodontal staging and grading. A basic periodontal examination, assessment of the gums and caries (tooth decay), was carried out at each periodontal inspection.

The records we reviewed included information about the patient's current dental needs, past treatment, medical history and treatment options. The diagnosis and treatment plan for each patient was clearly recorded and showed that treatment options were discussed with the patient. A medical and dental history assessment was completed at the patient's initial consultation and was checked for any changes at each subsequent appointment.

The patient population was at high readiness for deployment, including short notice deployment, so dental fitness was a priority to meet operational requirements. The military dental fitness targets were closely monitored by the SDO. At the time of the inspection, the practice was below the required target. For example, Category 1 (dentally fit to deploy with minimum risk of dental morbidity for 12 months) was at 68% (target is > 75%). This was due to challenges with staffing levels and dispersal of the patient population. Both Regional Headquarters and the Chain of Command were aware and no concerns had been raised. A recovery plan was in place to improve on the targets.

### Health promotion and prevention

The deployed dental nurse was the lead for oral health education (OHE). The patient records we reviewed showed proposed treatment pathways and information given to patients was in accordance with the Delivering Better Oral Health toolkit. OHE interventions in relation to diet, smoking, alcohol use and oral hygiene were provided. If a patient scored high on the alcohol screen tool (referred to as AUDIT-C) the SDO provided an alcohol briefing and gave the patient a leaflet that provided information on units, associated risks and the benefits of reducing alcohol consumption. If further intervention was merited then a referral could be made to the medical centre. Patients could also be referred to the medical centre for smoking cessation. An OHE audit was planned once the dental nurse returned to the service.

High concentration sodium fluoride toothpaste, fissure sealants and fluoride varnish treatment options were available. A variety of dental health promotion information was available in the waiting area including a display in relation to tooth decay and sugar in drinks. Information leaflets about mouth ulcers, smoking, smokeless tobacco and mouth cancer were available for patients to take away. A unit health fair had not been held since the SDO joined the practice.

### Staffing

The designated staffing complement at the time of the inspection was appropriate for the size of the patient population. Due to recent deployments and a vacancy for a civilian dental nurse, staffing levels had been low. This had led to access issues and consistency of care delivery; reflected in patient feedback about the service. A minimal staffing dental standard operating procedure was in place and the SDO made every effort to forecast staff availability. An open request was in place for a locum dental nurse to provide cover for the dental nurse deployed. The first request was placed in August 2022 with no success, so a further request was submitted in March 2023. On some occasions just the SDO and practice manager worked at the practice. The practice manager is also a dental nurse so provided chairside support. Regional Headquarters was aware of the workforce limitations and had loaned dental nurses from other dental centres to the practice. Alternatively, patients could travel to the next closest Defence Primary Healthcare (DPHC) dental centre, approximately a 45 minute drive away. A civilian dental nurse had been recruited but there were delays with the onboarding process, mainly in relation to security clearance.

All staff had completed the DPHC induction. We spoke with a dental nurse on loan from another dental centre and they had been given a local practice induction. The practice manager monitored the status of mandatory training. All staff were up-to-date with required training. An in-service training programme was in place.

Staff were responsible for their own continuing professional development (CPD) records, required for maintaining registration with the General Dental Council (GDC). They were given the opportunity to attend CPD sessions when they were available, encouraged to attend DPHC webinars and the biannual regional training day. CPD certificates were uploaded and recorded on the GDC template. Both the SDO and practice manager attended regional meetings with the regional team at Catterick.

### Working with other services

The SDO attended the Heads of Department meetings and the Command Update Briefs.

For advanced restorative treatment and endodontics, referrals were made through the DPHC Managed Clinical Network and to the enhanced practitioner at Edinburgh Dental Centre. For oral surgery, patients were referred to Dundee Dental Hospital. The waiting time from referral to consultation was approximately 4 weeks. The SDO monitored the progress of referrals.

### Consent to care and treatment

Patients we spoke with confirmed they were given information about treatment options and the risks and benefits of these so they could make informed decisions. The patient records we looked showed verbal or written consent was obtained depending on the treatment undertaken. The SDO had a good awareness of the Mental Capacity Act (2005) and how it would apply to their patient population.

# Are Services Caring?

### Respect, dignity, compassion and empathy

As there was no response to the Defence Medical Services Regulator patient satisfaction survey or to the inspection feedback cards, we relied on direct interviews with 6 patients for feedback about the service. All patients said staff treated them with kindness, respect and compassion.

Patients told us they were given adequate time for their appointments so they did not feel rushed. Patients who experienced dental anxiety described how the Senior Dental Officer (SDO) worked with them to reduce their anxiety so they could have the treatment they needed. One patient gave a detailed account of how they were given a longer appointment and a handheld mirror so they could see what was happening.

Although there was access to a translation service, staff had not needed to use this service.

### Involvement in decisions about care and treatment

Feedback from patients suggested the SDO provided clear information to support patients with making informed decisions about treatment choices. This included verbal explanations and printed information. The SDO talked through treatment options with patients and checked for their understanding. The dental records we looked at confirmed patients were involved in decision making about the treatment choices available.

# Are Services Responsive?

### Responding to and meeting patients' needs

The Senior Dental Officer (SDO) followed National Institute for Health and Care Excellence guidelines in relation to recall intervals between oral health reviews; between 3 and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. The SDO was aware of the recent Managed Clinical Network delivered presentations regarding the themes of risk and recall. Patients could make routine appointments between their recall periods if they had any concerns about their oral health.

Although satisfied with their treatment and care, some of the patients we spoke with raised concern about the practice being closed late in 2022. We noted from practice meeting minutes that this issue had been raised via patient feedback to the practice. The practice had been closed when the SDO and practice manager deployed. During this period, the SDO confirmed that patients had been informed of the closure and that they had access to Leuchars Dental Centre.

### Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in February 2023 and no actions were identified. Parking, wheelchair access and an accessible toilet were available. A hearing loop was not required based on the needs of people who used the building. Although minimal diversity was identified within the patient population, it was clear individual patient needs were considered and appropriate plans would be developed if and when required.

All staff were required to complete training in equality and diversity and the majority of staff were in-date for the training. A training session was scheduled in May 2023 for staff who needed it.

### Access to the service

At the time of the inspection, the next available routine appointment could be accommodated within a week. Urgent appointment slots were available each day. Patients had access to a dental hygienist at Leuchars Dental Centre.

Information about the service, including opening hours and access to an emergency out-of-hours (OOH) service, was displayed in the practice and through the practice information leaflet. The OOH service was provided by NHS 24.

### Concerns and complaints

The SDO was the lead for complaints. Complaints were managed in accordance with the Defence Primary healthcare complaints policy. Staff had received training in managing complaints. A process was in place for managing complaints, including a complaints register for written and verbal complaints. Complaints were a standing agenda item at the practice meetings.

Patients were made aware of the complaints process through the practice information leaflet and information in the waiting area. A complaints, compliments and suggestions box was located in the waiting area along with forms to complete. Feedback from patients indicated they knew how to make a complaint.

# Are Services Well Led?

### Governance arrangements

The practice worked to the following mission statement:

"To provide safe and effective healthcare, which meets the needs of the patient and the Chain of Command to reduce dental morbidity on operations."

The Senior Dental Officer (SDO) had taken up post at the practice in August 2022 and had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for the day-to day administration of the service. Staff had lead roles in specific areas. Some of the lead roles for the dental nurse deployed at the time of the inspection had been temporarily reallocated to other staff. However, the dental nurse was continuing to fulfil some roles remotely, including elements of infection prevention and control (IPC) and ordering stock. The dental nurse was due to return to the practice at the end in June 2023.

Practice meetings were held each Monday. The deployed dental nurse attended the meetings remotely to ensure they remained connected to the practice and maintained oversight of their lead roles. Meeting minutes were distributed to all staff to read and sign. A standing agenda was used for the meetings with select items discussed on a rolling monthly programme.

The regional Principal Dental Officer was the lead for business risk and clinical lead. Although the SDO was the health care governance lead, they were not fully familiar with all the practice system and processes. The practice manager had good oversight and regularly reviewed governance and risk management systems to ensure they were up-to-date. In such a small practice it is advantageous if all staff have an awareness of how to use operational systems and access information. The staff team acknowledged this would be addressed once the team stabilised through the return of the deployed dental nurse and recruitment of a civilian dental nurse.

A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were local dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff were familiar with these and they referred to them throughout the inspection. The General Dental Council standards were displayed in the practice.

Internal and regional processes were established to monitor service performance. Key performance indicators and dental targets were reviewed by Regional Headquarters and the Chain of Command. The practice used the Health Assessment Framework (eHAF); internal quality assurance system used to monitor safety and performance. The practice received an internal management action plan review in March 2023 following a full internal assurance review in June 2022. Feedback was given and the staff team completed the actions by April 2023. The regional team monitored the performance of the practice and used assurance information for Governance, Performance, Assurance and Quality (GPAQ) analysis undertaken at regional level.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Each member of staff had a login password to access the electronic systems and were not permitted to share their passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. A reporting system was in place should a confidentiality breach occur. Staff had completed the mandated Defence information management training, data protection training and training in the Caldicott principles to protect confidential patient information.

### Leadership, openness and transparency

Although the team has had limited consistent time together to form solid links, we noted a cohesiveness and positive staff morale. Staff worked well together with the collective aim to provide patients with a good standard of care. They said there was an open and transparent culture and were confident any concerns they raised would be addressed without judgement. They were familiar with whistle blowing arrangements. Whistleblowing information was displayed on the notice board.

We identified that a reduced workforce, recent irregular working routines and geographic remoteness was a risk to the team feeling isolated and detached from the wider Defence dental service. The SDO confirmed the practice team was well supported including on-site and remote mentorship. This support has been provided by the regional team, Neptune Dental Centre and the Principal Dental Officer. In addition, further engagement was planned with the SDO at Kinloss Dental Centre.

### Learning and improvement

Although there had been limited capacity for quality improvement activity, audits had taken place. An audit register was in place. It included the frequency of the audit, date completed, when the audit was next due and who completed the audit. The register included a link to the full audit. The environment and equipment were regularly monitored. Regular auditing of IPC and radiology took place. A fluoride audit was completed in May 2022 and the prescription log was reviewed quarterly with the last review taking place in January 2023.

Informal links within the region were established for peer review. The SDO was establishing new networks within the sub region for the purpose of clinical peer review as well to form links for peer-to-peer mentorship focusing on practice leadership and management.

Mid and end of year staff appraisals were up-to-date.

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

Options were in place for patients to leave feedback about the service including a suggestions box in the waiting area system and a quick response or QR code to access the patient experience survey. The GPAQ dashboard facilitated the monitoring of patient feedback. It showed 84 patients responded with feedback from June to February 2023. Patient feedback was discussed at practice meetings and also shared with Regional Headquarters.

A theme to the feedback concerned the frequency of the closure of the dental centre due to staff deployments. To address this issue, the practice approached the Regional Headquarters to request additional staff to allow the practice to open for routine treatment. This led to a service improvement.

Staff had the option to complete the organisational feedback surveys. In addition, staff could provide feedback at practice meetings and through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.