

Dr. Damian Allen

D B Allen - Rawtenstall

Inspection Report

1 Bacup Road, Rawtenstall,
Rossendale,
Lancashire, BB4 7NG
Tel: 01706 215627
Website: www.damianallendental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 23 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

Located close to Rawtenstall town centre and close to public transport links, the practice provides private dental

care for adults and children. Treatments include general and cosmetic dentistry, including dental implants. There are three surgeries at the practice. Patients who are unable to use the stairs can be seen in the ground floor surgery.

The practice is open Monday 08:30 to 19:00, Tuesday and Thursday 08:30 to 17:25, Wednesday 08:30 to 13:00 and Friday 08:30 to 17:00. It is closed between 13:00 and 14:00 each day for lunch.

The dental team currently comprises two dentists, two dental nurses, a practice manager and a receptionist.

The practice owner is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We reviewed feedback from 49 patients as part of the inspection. Patients were extremely positive about the staff and standard of care provided by the practice. Patients commented that they felt involved in all aspects of their care and found the staff to be helpful, respectful, friendly and were treated in a clean and tidy environment.

Our key findings were:

- The practice was well organised, visibly clean and free from clutter.

Summary of findings

- An infection prevention and control policy was in place. We saw the sterilisation procedures followed recommended guidance.
- Systems were in place for recording accidents and significant events
- Practice meetings were used for shared learning, including 'cascade' training.
- The practice had a safeguarding policy and staff were aware on how to escalate safeguarding issues for children and adults should the need arise.
- Staff received annual medical emergency training. Equipment for dealing with medical emergencies reflected guidance from the resuscitation council.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Patient feedback was regularly sought and reflected upon.
- Patients could access urgent care when required.
- Dental professionals were maintaining their continued professional development (CPD) in accordance with their professional registration and some of this was achieved through the provision of 'cascade' training at the practice.

- A complaints process was in place but the practice had never received a complaint.
- The practice was actively involved in promoting oral health.

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

- Review the practice's process to ensure the Infection Prevention Society (IPS) audit is completed on a six monthly basis.
- Review the practice's incident management policy to ensure it captures the full range of incidents that could occur at the practice, including significant events.
- Review the practice recruitment policy and procedures to ensure references for new staff appointed are requested and recorded.
- Review the approach to staff training, including safeguarding training, to ensure it meets mandatory training needs and the Continuing Professional Development needs of staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Effective infection prevention and control (IPC) procedures were in place. The practice was clean, tidy and clutter-free.

Equipment for decontamination procedures, radiography and general dental procedures were tested and checked according to manufacturer's instructions.

Medicines were stored appropriately, both for medical emergencies and for regular use and were in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Staff we spoke with were knowledgeable about safeguarding systems for adults and children.

The practice had processes for recording and reporting accidents and significant events. The incident policy was limited in detail as it just made reference to accidents.

Recruitment processes were in place but verbal references taken were not being recorded.

Relevant risk assessments were in place for the practice.

No action



Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Dental professionals referred to resources such as the National Institute for Health and Care Excellence (NICE) guidelines and the Delivering Better Oral Health toolkit (DBOH) to ensure their treatment followed current recommendations.

Staff obtained consent, effectively managed patients of varying age groups and made referrals to other services in an appropriate and recognised manner.

Staff who were registered with the General Dental Council (GDC) met the requirements of their professional registration by carrying out regular training and continuing professional development (CPD). Some of the CPD requirements were met through 'cascade' training.

No action



Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Patients were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 49 responses all of which were very positive, with patients stating they felt listened to and received the best treatment at that practice.

Dental care records were kept securely on computer systems which were password protected and backed up at regular intervals.

No action



Summary of findings

We observed patients being treated with respect and dignity during our inspection and privacy and confidentiality were maintained for patients using the service. We also observed staff to be welcoming and caring towards patients.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice were able to provide urgent dental care and all emergency patients were seen on the day they contacted the practice.

Patients had access to telephone interpreter services if required and the practice provided a range of facilities for different disabilities including a hearing loop, lowered reception area and a ground floor surgery.

No action



Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

There was a clearly defined management structure in place and all staff felt supported and in their roles. The practice manager was responsible for the day to day running of the practice. Staff said there was an open culture at the practice and they felt confident raising any concerns.

There were dedicated leads in IPC and safeguarding, as well as various policies for staff to refer to.

The practice held weekly staff meetings, which provided an opportunity to openly share information and discuss any concerns or issues at the practice

The practice had a comprehensive programme of audit to monitor their performance and help improve the services offered. IPC audits had not been undertaken every six months as required.

The practice conducted patient satisfaction surveys through-out the year and this was collated and fed back to staff and patients.

No action



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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 23 November 2016. It was led by a CQC inspector and supported by a dental specialist advisor.

During the inspection, we spoke with the practice manager, the principal dentist and two dental nurses. We reviewed policies, protocols, certificates and other documents as part of the inspection.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place for managing accidents and incidents, including significant events. Accidents were recorded in an accident book. Just one accident had been reported in the last 12 months and we could see from the accident book that this was a sharps injury a member of staff sustained. A form was in place for recording and analysing significant events. The practice manager said there had never been a significant event. When we looked at the detail in the incident policy we noted it was limited to the management of accidents, such as sharp injuries. We highlighted this to the practice manager who said they would take this into consideration when the policy was next reviewed.

The staff we spoke with were clear about what needed to be reported in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013 (RIDDOR).

The staff we spoke with were aware of the need to be open, honest and apologetic to patients if anything should go wrong; this is in accordance with the principles Duty of Candour principle which states the same.

The principal dentist received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). If the alert was relevant to the operation of the practice then it was shared with the staff team. The MHRA is the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness.

Reliable safety systems and processes (including safeguarding).

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. A sharps risk assessment had been completed in September 2016 and this was supported by a sharps policy that was also reviewed in September 2016. A sharps injury checklist was in place and all staff were aware of what to do in the event of a sharps injury. Staff confirmed that disposable syringes were used.

The dentist told us they routinely used a rubber dam when providing root canal treatment to patients in accordance with guidance from the British Endodontic Society. A

rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We reviewed the practice's policy for adult and child safeguarding which contained contact details of the local authority child protection and adult safeguarding. The practice manager was the safeguarding lead and had completed safeguarding training along with the receptionist within the last 12 months. The principal dentist had refreshed their safeguarding training in November 2016. The dental nurses had not completed safeguarding training and the practice manager said it was provided at practice meetings when particular policies were discussed. We noted that the child safeguarding policy was discussed at the practice meeting in January 2015. The staff we spoke with were clear about how to report a safeguarding concern.

The practice had a whistleblowing policy in place that included external contacts. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations.

Employer's liability insurance was in place for the practice. Having this insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969 and we saw the practice certificate was up to date.

Medical emergencies

The practice followed the guidance from the Resuscitation Council UK and had sufficient arrangements in place to deal with medical emergencies. Procedures were in place for staff to follow in the event of a medical emergency and all staff had received training in basic life support including the use of an Automated External Defibrillator. An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

The practice kept medicines and equipment for use in a medical emergency. These were in line with the Resuscitation Council UK and British National Formulary guidelines. All staff knew where these items were located.

Are services safe?

We saw the practice kept logs which indicated the emergency equipment, emergency medical oxygen cylinder, emergency drugs and AED were routinely checked. This supported with ensuring the equipment was fit for use and the medication was within the manufacturer's expiry dates. We checked the emergency medicines and found they were of the recommended type and were all in date. Mercury and bodily fluid spillage kits were in place in the event that staff should need to use them.

The staff team received annual training in how to respond to medical emergencies and they last received training in December 2015.

Staff recruitment

We reviewed the recruitment file for the most recently recruited member of staff to check that the member of staff had been recruited appropriately. The file contained proof of identity, qualifications, immunisation status, confirmation of General Dental Council (GDC) registration and a Disclosure and Barring Service (DBS) check. A DBS check helps employers to make safer recruitment decisions and can prevent unsuitable people from working with vulnerable groups, including children. References were not on record and the practice manager said they took a verbal reference but had not recorded it. The practice manager provided evidence to demonstrate that all staff were appropriately immunised and that a DBS check had been sought when they were first recruited. They said written references were not always requested.

Monitoring health & safety and responding to risks

The practice manager was the nominated health and safety lead for the practice. The practice manager confirmed that an environmental risk assessment was completed annually (last undertaken in May 2016) and that visual checks of the premises was conducted each week; these visual checks were not recorded. A risk assessment is a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm.

We observed a number of doors without a fire closure device. The practice manager advised us that a fire risk assessment undertaken six years ago by an external company recommended the fitting of fire doors but it was

not a required action. The principal dentist agreed to arrange another fire risk assessment to clarify the position. An internal fire risk assessment was undertaken by the practice manager in August 2016.

Smoke alarms were in place and records confirmed that firefighting equipment and the fire alarm were regularly checked. The last fire drill took place on 8 November 2016.

We looked at the Control of Substances Hazardous to Health (COSHH) file. COSHH files are kept to ensure providers contain information on the risks from hazardous substances in the dental practice. A dedicated member of staff was responsible for ensuring the COSHH file was up-to-date. We found the practice had in place safety data sheets; information sheets about each hazardous product, including handling, storage and emergency measures in case of an accident. The practice manager confirmed that if any changes were made to COSHH products then it was communicated to staff at the practice meetings.

Infection control

We observed one of the dental nurses carrying out a decontamination cycle in the dedicated decontamination room; this involved the cleaning, sterilising, packing and storing of dental instruments. This process was in accordance with the Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. Produced by the Department of Health, this guidance details the recommended procedures for sterilising and packaging instruments.

We looked at the decontamination and treatment rooms. The rooms were clean, drawers and cupboards were clutter free with adequate dental materials. There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria. Legionella is a term for particular bacteria which can contaminate water systems in buildings. Staff described the method used and this was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out in for the practice in 2010 and this remained valid for the practice.

The practice stored clinical waste securely and an appropriate contractor was used to remove it from site.

Are services safe?

Waste consignment notices were available for the inspection and the registered manager confirmed that all types of waste, including sharps and amalgam was collected on a regular basis.

The practice employed a cleaner to carry out routine cleaning of the premises. We observed the cleaner used different coloured cleaning equipment, which followed the national guidance. The cleaning equipment was not stored correctly and we highlighted this to the practice manager at the time of the inspection.

The practice manager had carried out an Infection Prevention Society (IPS) audit on 10 November 2016 and an action plan was produced following the audit. The practice manager confirmed that the audit undertaken previous to this was approximately 18 months ago. We highlighted that IPS audits are required to be completed every six months and both the practice manager and the dentist said they would ensure this happened going forward.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. We saw evidence of

up-to-date examinations and servicing of equipment, such as the X-ray equipment, autoclave and the compressor. Portable electrical appliances were tested on 19 November 2016 to ensure they were safe to use.

Local anaesthetics were stored appropriately and a log of batch numbers and expiry dates was in place.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999 and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. The practice kept a detailed radiation protection file, including the names of the Radiation Protection Advisor, the Radiation Protection Supervisor and Health and Safety Executive notification. The local rules and maintenance certificates were contained in the file.

We saw all the staff were up-to-date with their continuing professional development training in respect of dental radiography. The practice was undertaking regular analysis of their X-rays through an annual audit cycle. X-ray audits were completed for each dentist and the last audit was completed in September 2016. The audits were in accordance with the National Radiological Protection Board (NRPB) guidance.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found the dental team were following guidance and procedures for delivering dental care. The dental records we looked at were excellent. A comprehensive medical history form was completed with patients and this was checked at every visit. A thorough examination was carried out to assess the dental hard and soft tissues including an oral cancer screen. The dentists also used the basic periodontal examination (BPE) to check patient's gums. This is a simple screening tool that indicates how healthy the patient's gums and bone surrounding the teeth are. The dental records we looked at informed us that patients were advised of the findings, treatment options and costs.

The dentist was familiar with the current National Institute for Health and Care Excellence (NICE) guidelines for recall intervals, wisdom teeth removal and antibiotic cover. Recalls were based upon individual risk of dental diseases.

The dentist used their clinical judgement and guidance from the Faculty of General Dental Practitioners (FGDP) to decide when X-rays were required. A justification, grade of quality and report of the X-ray taken was documented in the patient dental care records.

Health promotion & prevention

We found the practice was proactive about promoting the importance of good oral health and prevention. There was evidence in the dental records we looked at that the dental team applied the Department of Health's 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive care and advice to patients. Preventative measures included providing patients with oral hygiene advice such as tooth brushing technique, fluoride varnish applications and dietary advice. Smoking and alcohol consumption was also checked where applicable.

The practice reception displayed a range of dental products for sale and information leaflets were also available to aid in oral health promotion.

Staffing

An induction checklist was in place to inform new staff about the way the practice operated. The checklist was not in place for recently recruited staff so we spoke with a

member of staff who confirmed their induction had been in accordance with the checklist. The induction process included making new members of staff aware of the practice's policies, the location of emergency medicines and arrangements for fire evacuation procedures.

All staff had received annual training in responding to medical emergencies. The practice manager described how a form of 'cascade' training was used at the practice. This means that one or more team members receive training in a specific topic and then share their knowledge with the rest of the staff team. Staff said 'cascade' training was provided at induction and practice meetings for safeguarding and IPC. We could see from various practice meeting minutes over the last 12 months that sharps, mental capacity and child protection were discussed. There was very little information in the minutes to make a judgement about the quality of this training. This approach to training was not in accordance with the staff training policy and we highlighted this to the practice manager at the time of the inspection.

Staff told us they felt well supported with maintaining their continuous professional development (CPD) required for registration with the General Dental Council (GDC). They confirmed that they received an appraisal every six months.

Staff had an annual appraisal and the registered manager provided evidence to show these had taken place. CPD and training needs were discussed at appraisal.

Working with other services

The dentist we spoke with confirmed they would refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. Referral letters were used to send all the relevant information to the specialist. Details included patient identification, medical history, reason for referral and X-rays if relevant. The dentist had a process in place to monitor the progress of referrals.

The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

Consent to care and treatment

We spoke with the principal dentist about how they implemented the principles of informed consent. Informed

Are services effective?

(for example, treatment is effective)

consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then if appropriate documented in a written treatment plan. The patient would be provided with a copy of the plan and a copy would be retained in the patient's dental care record.

The principal dentist was clear about the principles of the 2005 Mental Capacity Act (MCA) and the concept of Gillick competence. The MCA is designed to protect and empower individuals who may lack the mental capacity to make their

own decisions about their care and treatment. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment, without the need for parental permission or knowledge. The child would have to show sufficient mental maturity to be deemed competent.

The principal dentist provided an example of how treatment was provided to a patient who lacked mental capacity and how they involved the patient's relative to ensure the treatment was clearly explained. This was in accordance with the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 49 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity and that staff were sensitive to their specific needs.

We observed all staff maintained privacy and confidentiality for patients on the day of the inspection. Practice computer screens were not overlooked in reception and treatment rooms which ensured patient's confidential information could not be viewed by others. We

saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records were stored electronically and computers were password protected to ensure secure access. Computers were backed up and passwords changed regularly in accordance with the Data Protection Act. Staff were confident in data protection and confidentiality principles.

Involvement in decisions about care and treatment

Review of the CQC comment cards and our observation of dental records demonstrated that patients were involved in decisions about their care. Posters treatment costs were displayed in the waiting area. The practice website provided patients with information about the range of treatments which were available at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw the practice waiting area displayed a variety of information including the practice opening hours, emergency 'out of hours' contact details, complaints and treatment costs. Leaflets on oral health conditions and preventative advice were also available.

The practice manager confirmed that if a patient made contact seeking an urgent appointment then they would be seen that day even if it meant waiting until a dentist was free.

Tackling inequity and promoting equality

Reasonable adjustments to prevent inequity to any patient group. The practice completed a disability access audit in May 2016. This audit is an assessment of the practice to ensure it meets the needs of people with a disability. There was a lowered area at the reception desk for people using wheelchairs or mobility scooters, and a hearing loop for

patients with auditory needs. An accessible toilet was not available but the practice had an arrangement with the shop next door for patients to use its accessible toilet if needed. Staff had access to a translation service if required.

Access to the service

Opening hours were displayed in the premises, in the practice information leaflet and on the practice website. Patient feedback indicated there was good access to routine and urgent dental care. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

Concerns & complaints.

The practice manager had the lead for managing complaints. A complaints procedure was in place which provided guidance on how to handle a complaint.

Information for patients about how to make a complaint was displayed in the waiting areas. The practice manager confirmed that no complaints had been received about the practice in the 12 years it had been in operation.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day-to-day running of the practice. Staff we spoke with said the management and leadership arrangements were effective. They said the practice was well organised and they were clear about their roles and responsibilities.

Clinical governance processes were in place to continuously improving the quality of their services and ensure high standards of care delivery. These included a portfolio of regularly reviewed operational policies and procedures, risk management systems and a comprehensive audit programme.

Policies were reviewed on a regular basis. Risk management processes were in place to ensure the safety of patients and staff members. For example, we saw risk assessments relating to the environment, fire, sharps injuries and the use of the autoclave. Dedicated staff were identified who had a lead in areas, such as complaints, safeguarding and infection prevention and control.

A business continuity plan was in place, which sets out how the service would be provided if an incident occurred that impacted on its operation.

Leadership, openness and transparency

Staff told us there was an open culture within the practice that encouraged candour, openness and honesty to promote the delivery of high quality care, and to challenge poor practice. From the minutes of weekly practice meetings and from discussions with staff, it was evident the practice worked as a team and that staff were comfortable raising matters.

All staff were aware of who to raise issues and told us the practice manager was approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice.

Learning and improvement

Clinical and non-clinical audits were routinely carried out as part of an audit programme. An audit is an objective assessment of an activity designed to improve an individual or organisation's operations. Audit topics included: emergency drugs; patient consent; patient feedback; medical history taking; radiography and infection prevention and control. The audits we saw were detailed and included conclusions and actions.

We asked the registered manager for an example of how the service had improved based on audit findings. The registered manager highlighted how raising awareness of what should be included in patient records had led to marked improvements in dental record keeping.

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

A process was in place to seek feedback from patients. Feedback questionnaires were issued to every fifth patient on the first Tuesday of every month. We looked at the most recent survey report and no concerns had been raised or suggestions for improvement had been made for by any patients.

Staff told us their views were sought and listened to and that they were confident to raise concerns or make suggestions to the practice manager.