Crosbie Care Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 15 June 2015 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 not providing well-led care in accordance with the relevant regulations.

Crosbie Care Limited is a general dental practice in central London offering only private dental treatment. The practice treats adults and children.

The premises consist of a communal waiting room (shared by other providers in the same premises) which is next to the treatment room.

The staff at the practice consists of the provider (the principal dentist) and a dental nurse.

On the day of our inspection, no patients were scheduled to be seen. We reviewed two comment cards that had been completed by patients. These reflected positive experiences of the care and treatment they had received. Patients felt they were listened to, treated with dignity and respect and cared for in a safe and hygienic environment.

Our key findings were:

- The practice provided evidence based dental care which was focussed on the needs of the patients.
- Patients told us through comment cards they were treated with kindness and respect by staff.
- Patients were able to make routine and emergency appointments to support their care and treatment needs. There were clear instructions for patients regarding out of hours care.
- The practice did not have systems in place to ensure the safe maintenance and operation of the X-ray equipment or dental air compressor. However, the provider took action to rectify this immediately after our inspection.

Summary of findings

- The practice did not have effective systems in place to mitigate fire safety risks. However, the provider took action to address this immediately after our inspection.

We identified regulations that were not being met and the provider must:

- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.

You can see full details of the regulations not being met at the end of this report

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

- Review the availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure a full audit process where actions needed are identified and monitored for completion

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.

There were effective systems in place in the areas of clinical waste control and management of medical emergencies. The staffing levels were appropriate for the provision of care and treatment.

Although there were largely effective systems in place for infection control, part of the treatment room was carpeted which was not in accordance with Department of Health guidance. The provider did not have an effective system in place for the safe maintenance of the X-ray equipment or the dental air compressor. We found there were in-effective fire safety procedures in place.

Are services effective?

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

The practice provided evidence based dental care which was focussed on the needs of their patients. We saw examples of effective collaborative team working. The staff were up-to-date with current guidance and received professional development appropriate to their role and learning needs. Staff, who were registered with the General Dental Council (GDC), had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration. Patients' dental care records we reviewed provided a full and accurate account of the care and treatment they had received.

Are services caring?

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

Patients told us (through comment cards) they had very positive experiences of dental care provided at the practice. Patients felt they were listened to, treated with respect and were involved with the discussion of their treatment options which included risks, benefits and costs. We observed the staff to be caring, compassionate and committed to their work. Staff spoke with enthusiasm about the care and treatment they provided to 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 provided friendly and personalised dental care. Patients could access routine treatment and urgent or emergency care when required. Although the practice was not open every week day, there was a system in place to respond to patients who may have urgent care and treatment needs.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

The principal dentist and dental nurse worked well together as a team. The provider was seen as approachable by the dental nurse who felt supported in their role and able to raise any issues or concerns if needed. The culture within the practice was seen as open and transparent and encouraged candour and honesty.

The practice had systems in place to regularly audit X-ray quality and infection control. The provider did not always develop action plans when areas of improvement had been identified.

Summary of findings

We also found that there was lack of an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The principal dentist confirmed they would be undertaking immediate action for mitigating the various risks.

Crosbie Care Limited

Detailed findings

Background to this inspection

The inspection was carried out on 15 June 2015 by an inspector and a dental specialist advisor. We reviewed information received from the provider prior to the inspection. On the day of our inspection we looked at practice policies and protocols and other records relating to the management of the service. We spoke to the provider (who was the principal dentist) and the dental nurse. We reviewed two comment cards that had been completed by patients.

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?

This informed our view of the care provided and the management of the practice.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood the process for accident and incident reporting including their responsibilities under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We reviewed the accident book and found no accidents had been recorded. However, staff were able to describe to us the actions they would take if an accident or incident occurred. This included discussion and analysis of the incident to identify if any improvement actions were needed.

Reliable safety systems and processes (including safeguarding) We looked at the documentation around safeguarding and abuse. The practice had policies and procedures in place for child protection and safeguarding people using the service which included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had not completed recent safeguarding training, however; they demonstrated to us their knowledge of how to recognise the signs and symptoms of abuse and neglect.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

A risk management process had been undertaken for the safe use of sharps (needles and sharp instruments) to minimise the risk of inoculation injuries to staff members. Information available for staff detailed the actions they should take if an injury from using sharp instruments had occurred.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK and British National Formulary (BNF). This included face masks for both adults and children. Oxygen and medicines for use in an emergency were available. Records completed showed regular checks were done to ensure the equipment and emergency medicine was safe to use. We noted there was no portable non-powered suction apparatus which was not in line with Resuscitation Councul UK guidance or spacer for bronchodilation which was not in line with BNF guidance. The provider resolved to immediately address this.

Records showed all staff had recently completed training in emergency resuscitation and basic life support including the use of the automatic external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

We observed the AED was housed in an accessible cupboard in the hallway and it was available for use by other providers in the building. The provider agreed that each day the practice was open, they would check the AED was available and functioning.

Staff recruitment

There were effective recruitment and selection procedures in place. Although the dental nurse had been employed by the previous owner, the provider had carried out appropriate checks when taking over their employment. This included evidence of professional registration with the General Dental Council, an identity verification and checks with the Disclosure and Barring Service. The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The provider described to us the process they would follow in the event they needed to recruit additional staff members. This included application forms, employment history, evidence of qualifications and photographic evidence of the employee's identification and eligibility to work in the United Kingdom. The provider told us the qualification, skills and experience of each employee would be fully considered as part of the interview process.

Monitoring health & safety and responding to risks

There was a lack of effective arrangements in place to deal with foreseeable emergencies. We found the practice had been assessed for risk of fire and fire extinguishers were available. However, the fire risk assessment which had been carried out in April 2014 (on behalf of the landlord of the premises) had made several recommendations which had not been implemented. For example, this included to draft a written co-ordinated evacuation procedure to determine roles and responsibilities and to provide signage to indicate means of escape. We found there was no evacuation procedure in place or any signage to indicate

Are services safe?

an escape route. We discussed this with the provider who told us the landlord had not taken any action to address the concerns raised. However, the provider resolved to meet with the other tenants occupying the premises to discuss the significant potential risks to peoples' safety and to put measures in place to mitigate these risks. After our inspection the provider confirmed he had met with the other tenants of the premises to discuss the safety concerns and put immediate measures in place to reduce any risks.

There was a lack of effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. The practice did not maintain a COSHH file in order to manage risks (to patients, staff and visitors) associated with substances hazardous to health. We discussed this with the provider who agreed this should be in place and resolved to address this immediately.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments and hand hygiene.

We found the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. An exception to this was the presence of carpet in part of the treatment room. The practice policy and procedures on infection prevention and control were accessible to staff.

We examined the facilities for cleaning and decontaminating dental instruments. We found there was a clear flow from 'dirty' to 'clean.' The dental nurse explained to us how instruments were decontaminated and sterilised. They told us they wore eye protection, an apron, heavy duty gloves and a mask while instruments were decontaminated prior to being place in an autoclave (sterilising machine).

Instruments were inspected to check for any debris or damage throughout the cleaning stages using an illuminated magnifier in line with essential quality standards.

An autoclave was used to ensure instruments were decontaminated ready for the next use. We saw instruments were placed in pouches after sterilisation and dated to indicate when they should be reprocessed if left unused. We found daily, weekly and monthly tests were performed to check the steriliser was working efficiently and a log was kept of the results. We saw evidence the parameters (temperature and pressure) were regularly checked to ensure equipment was working efficiently in between service checks.

The practice had an on-going contract with a clinical waste contractor. We found the practice managed clinical waste and the safe disposal of sharps appropriately. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of. This was in line with the recommended guidance.

We looked at the treatment room where patients were examined and treated which appeared visibly clean. However, we noted that part of the room (leading from the door to the clinical area) was carpeted. This was not in accordance with HTM 01-05 guidance which states 'flooring in clinical care and decontamination areas should be impervious and easily cleanable. Carpets, even if washable, should not be used.' The provider told us he had considered removing the carpet but had felt patients (most of whom had been very loyal to the practice for many years) would not like it. After our inspection, the provider told us he had sought quotes to have the carpet replaced and would address this in due course.

Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near to the designated hand wash sinks to ensure effective decontamination. Patients were given a protective bib and safety glasses to wear each time they attended for treatment. There were good supplies of protective equipment for patients and staff members.

There was a good supply of cleaning equipment which was stored appropriately. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spreading.

Records showed a risk assessment process for Legionella had been carried out which ensured the risks of Legionella

bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk of patients and staff of developing Legionnaires' disease. (Legionella is a term for particular bacteria which can contaminate water systems in buildings.)

Equipment and medicines

There were some systems in place to check equipment had been serviced regularly, including the autoclave, fire extinguishers and oxygen cylinder. We were shown the annual servicing certificates. The records showed the service had an efficient system in place to ensure this equipment in use was safe, and in good working order. However, there was no evidence available to show when the dental air compressor had last been serviced. The provider showed us evidence after the inspection he had arranged for the compressor to be serviced.

A recording system was in place for the prescribing, recording, and dispensing of the medicines used in clinical practice. The systems we viewed provided an account of medicines prescribed, and demonstrated patients were given their medicines when required. The type, batch numbers and expiry dates for local anaesthetics used were recorded in patients' dental care records.

Radiography (X-rays)

We asked to see the provider's radiation protection file as X-rays were taken and developed at the practice. We also looked at X-ray equipment in use and talked with staff about its use.

We found the provider had completed radiation protection training in 2011 which was in accordance with the General Dental Council's continuing professional development requirements. Records showed the provider regularly audited the quality of X-ray images taken. This showed X-rays were taken to an acceptable standard and therefore minimised the risk of further (and unnecessary) X-ray exposure to patients. We saw evidence which demonstrated personal dosemeters used by the dentist and dental nurse recorded that they had not experienced unsafe levels of radiation exposure.

We found there were not suitable arrangements in place to ensure the safety of the X-ray equipment. For example, we found no record of an installation acceptance test or critical examination test for the X-ray set. The practice did not have local rules available which are required to ensure the equipment is operated safely. The provider told us they did not think these were required as they were the only person taking X-rays at the practice. The practice had not appointed a radiation protection adviser which meant procedures and equipment had not been assessed as safe by an independent expert.

We discussed these findings with the provider who resolved to address the issues immediately and suggested to us they would refer any patients requiring X-rays to another service until they were assured the appropriate documentation was in place confirming the equipment was safe to use.

The provider showed us evidence the day after our inspection they had applied to Public Health England for a complete assessment of the X-ray equipment and they had also appointed a radiation protection adviser. We were also shown evidence provided by the supplier of the X-ray equipment (installed two years ago) that it was safe to use at the time of installation in June 2013.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for people using best practice

We found the dentist regularly assessed each patient's gum health and took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken as well as an examination of a patient's soft tissues (including lips, tongue and palate) and their use of alcohol and tobacco. These measures demonstrated to us a risk assessment process for oral disease.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to wisdom teeth removal and in deciding when to recall patients for examination and review.

Health promotion & prevention

The practice promoted the maintenance or good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients. 'Delivering better oral health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health

Records showed patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice.

Staffing

Staff had undertaken training to ensure they were kept up to date with the core training and registration requirements issued by the General Dental Council. This included areas such as responding to medical emergencies and infection control and prevention.

There was an effective appraisal system in place which was used to identify training and development needs.

Working with other services

The practice had a system in place for referring patients for dental treatment and specialist procedures to other colleagues where appropriate. The dentist told us the practice involved other professionals and specialists in the care and treatment of patients where it was in the patient's best interest.

Consent to care and treatment

The dentist explained to us how valid consent from patients was obtained for all care and treatment. Records showed and staff confirmed individual treatment options, risks, benefits and costs were always discussed in detail with each patient and documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they wanted.

The practice staff demonstrated an understanding of how the Mental Capacity Act 2005 applied in considering whether or not patients had the capacity to consent to dental treatment. Staff explained to us how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The provider and dental nurse explained to us how they ensured information about patients was kept confidential. Patients' dental care records were stored securely. Staff demonstrated to us their knowledge of data protection and how to maintain confidentiality. Patients were able to have confidential discussions about their care and treatment in the treatment room.

Patients told us through comment cards they felt listened to and were treated with dignity and respect.

Involvement in decisions about care and treatment

The dentist told us they used a number of different methods including tooth models, display charts, pictures and leaflets to demonstrate what different treatment options involved so that patients fully understood. These were used to supplement a treatment plan which was developed following examination of and discussion with the patient.

The practice provided patients with information to enable them to make informed choices. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.

Patients were also informed of the range of treatments available and their cost in information leaflets available in the treatment room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had effective systems in place to ensure the equipment and materials needed were in stock or received in advance of the patient's appointment. This included checks for laboratory work such as crowns and dentures so that delays in treatment were avoided.

Staff reported (and we saw from the appointment book) the practice always scheduled enough time to assess and undertake patients' care and treatment needs. Staff told us they did not feel rushed or under pressure to complete procedures and always had plenty of time available to prepare for each patient.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from many different backgrounds, cultures and religions. They would encourage a relative or friend to attend who could translate or if not they would contact a translator.

The practice offered access for people using wheelchairs or those with limited mobility via a portable ramp. The toilet facilities were not wheelchair accessible, however; the layout of the building did not permit this to be facilitated.

Access to the service

The provider told us the practice used a 'virtual receptionist' service which meant calls were answered if the dental nurse was otherwise engaged in supporting patients. This service enabled patients to make routine and urgent appointments both during the day and out of normal opening hours. Each day the practice was open, emergency appointments were made available for people with urgent dental needs.

Concerns & complaints

There was a complaints policy which provided staff with detailed information about all aspects of handling complaints and compliments from patients.

Information for patients about how to make a complaint was available in the practice treatment room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. However, we found no information available on the practice website to support patients who may have wanted to complain.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place.

Are services well-led?

Our findings

Governance arrangements

Staff told us they felt well supported by the provider and were clear about their roles and responsibilities. Patients' dental care records provided a full and accurate account of the care and treatment they had received and appropriate records relating to the management of the practice were maintained. The practice ensured the information they held was kept secure.

We also found that there was lack of an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. We noted risks arising from fire, X-ray equipment and substances hazardous to health had not been appropriately identified and mitigated.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty. Staff reported there was an open culture at the practice; they felt valued and supported by the provider. Staff reported they could raise issues at any time with the provider without fear of discrimination as they were very approachable, always listened to their concerns and generally took appropriate action where necessary.

Management lead through learning and improvement

There had been audits of infection prevention and control to ensure compliance with government HTM 01-05 standards for decontamination in dental practices. The most recent audit indicated the facilities and management of decontamination and infection control were generally well managed. However, the audit had highlighted areas for improvement including the unsuitability of the floor covering in the treatment room and the lack of procedures to deal with mercury or fluid spillages. The provider had not developed an action plan to address this.

The practice had completed an audit to assess the quality of X-ray images. This showed X-rays were taken to an acceptable standard which minimised the risk of further (and unnecessary) X-ray exposure to patients.

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

The practice regularly sought feedback from patients. We found the most recent survey had highlighted some patients had requested the option of card payments for their dental treatment. The provider was in the process of facilitating this in response to feedback received.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The practice did not have effective systems in place to; Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity Regulation 17 (1)(2)(a)(b)