C M Desai Limited

C M Desai Limited - Thurncourt

Inspection Report

51 Thurncourt Road
Leicester
LE5 2NN
Tel: 0116 2413182
Website: N/A

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Overall summary

We carried out this announced inspection on 20 November 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

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

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 not 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.

Background

The practice is located in Thurnby Lodge, in Eastern Leicester. It provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available on the street, within close proximity to the practice.

Summary of findings

The dental team includes three dentists, one dental nurse and one trainee dental nurse. The dental nurse and trainee dental nurse also undertake receptionist duties. Practice administration duties are shared between the two principal dentists.

The practice has one treatment room located in a bungalow. The practice have plans to refurbish and update the premises.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at C M Desai Ltd – Thurncourt are the two principal dentists.

On the day of inspection, we collected 16 CQC comment cards filled in by patients.

During the inspection we spoke with two dentists, the dental nurse and trainee dental nurse. We looked at practice policies and procedures, patient feedback and other records about how the service is managed.

The practice is open: Monday, Wednesday and Thursday from 9:30am to 12pm, Tuesday and Friday from 1.30pm to 4pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Most appropriate medicines and life-saving equipment were available. We found that midazolam was not held in the required dose and was in injectable form that was required to be administered into the mouth. The provider acted to rectify this immediately.
- The provider had not managed all risks to staff as they had not taken sufficient measures to mitigate the risk of sharps injuries.
- The practice staff had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. We were not provided with evidence of up to date training for one of the dentists on the day of our inspection. This was completed on the same date and sent to us after the inspection.
- The provider had thorough staff recruitment procedures.
- Not all clinical staff provided patients' care and treatment in line with current guidelines. We found a lack of detailed record keeping in patient notes.
- The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The provider had systems to deal with complaints; insufficient information was provided to complainants about external organisations that may be able to assist them.
- Governance arrangements required strengthening including audit activity.

We identified regulations the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.

Full details of the regulations the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review the practice's handling protocols of out of date medicines to ensure waste is segregated and disposed of in compliance with the relevant regulations and taking into account the guidance issued in Health Technical Memorandum 07-01.
- Review the process for examining radiographs and consider the use of an x-ray viewer would be appropriate.

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?

No action

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

The practice had systems and processes to provide safe care and treatment.

There was policy and process to help support learning and make improvements when things went wrong. We found that when issues arose, there was scope to improve recording of information to demonstrate improvement and learning outcomes.

Staff received training in safeguarding people and knew how to recognise the signs of abuse and how to report concerns. We were not provided with evidence of training for one of the dentists, this was completed on the day of inspection and sent to us.

Staff were qualified for their roles and the practice completed essential recruitment checks.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

Documentation held regarding the use of X-ray equipment in the premises required update and review.

The practice had mostly suitable arrangements for dealing with medical and other emergencies. We noted that midazolam was not held in the required dosage and was in injectable form that was required to be administered into the mouth. Immediate action was taken by the provider to rectify this.

Are services effective?

Requirements notice 

We found that this practice was not providing effective 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).

We found that that not all clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. For example, X-rays were not always graded and further detail was required in dental record keeping to show that patients' individual needs and preferences were established. We did not find that patients' current needs were always recorded.

The dentists told us they planned to move to an electronic patient record system with the aim to improve record keeping.

Summary of findings

Patients described the treatment they received as excellent, good and appropriate. The dentists told us they discussed treatment with patients so they could give informed consent; we found this was not always recorded in their dental care records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles.

Are services caring?

No action ✓

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

We received feedback about the practice from 16 people. Patients were positive about all aspects of the service the practice provided. They told us staff were caring, helpful and respectful.

Patients said that they were given helpful and informative explanations about dental treatment. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action ✓

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

The practice had made some reasonable adjustments for patients with disabilities. This included step free access and a toilet facility with a hand rail. The practice did not have a hearing loop or access to interpreter services at the time of our visit. Staff spoke other languages however, including Gujarati and Hindi. Following our inspection, the provider contacted us and told us that access to interpreter services was now in place and a hearing loop had been installed.

The practice took patients views seriously. They valued compliments from patients and told us they would respond to concerns and complaints quickly and constructively, if any were received.

Are services well-led?

Requirements notice ✗

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).

Summary of findings

The principal dentists had overall responsibility for the management and clinical leadership of the practice. The principal dentists were also responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. We identified that some policies required review to ensure they were specific to the practice and accurate.

There were some effective processes for managing risks, issues and performance. We also identified areas that required improvement such as responding to the risks presented by sharps injuries. Our review of records relating to a staff accident did not show that preventative measures were effectively deployed, as a result.

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, Equipment & premises and Radiography (X-rays)

The practice had systems to keep patients safe; we found areas that required practice review.

Staff showed awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had a safeguarding policy to provide staff with information about identifying, reporting and dealing with suspected abuse. The policy referred to the practice manager as being the lead for safeguarding; the practice did not employ a manager as duties were shared between the principal dentists. The policy did not identify named individual(s).

We saw evidence that staff received safeguarding training. We were not provided with evidence of training for one of the dentists; this was completed on the date of the inspection and sent to us.

Staff told us that notes could be handwritten on records to highlight any vulnerable patients e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy. The policy referred to the principal dentist and the practice manager to raise concerns with.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. We saw that rubber dam was available. We noted that patient record keeping required more detail. We looked at a patient record where a problem had occurred with the use of rubber dam; this had not been detailed in notes. We discussed this with the dentist.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. The plan was brief and did not include details of another practice that could be used in the event of the premises becoming un-useable. We were shown a separate book held that contained staff contact information. We discussed documentation being held off site so it could be accessed easily if required, in the event of an emergency.

The practice had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at four staff recruitment records. These showed the practice followed their recruitment procedure.

We checked that clinical staff were qualified and registered with the General Dental Council (GDC). Clinical staff had professional indemnity cover.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection equipment, such as smoke detectors were tested and firefighting equipment, such as fire extinguishers, were serviced within the past 12 months.

The practice had some suitable arrangements to ensure the safety of the X-ray equipment. A rectangular collimator had not been fitted to X-ray equipment. We were informed after the inspection that one had been ordered. Whilst we noted that the provider had taken on the services of a radiation protection advisor (RPA), we were not provided with documentation to show that the provider had consulted with the RPA. We saw local rules present although we did not view employer's procedures. They held required information in their radiation protection file. We noted that the file required review and update as older documentation was also stored.

We saw evidence that the dentists justified and reported on the radiographs they took. We found that not all radiographs were graded however. The practice carried out radiography audits.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

The practice held health and safety policies, procedures and risk assessments.

The practice had current employer's liability insurance.

Are services safe?

There were some systems to assess, monitor and manage risks to patient safety. We identified areas for review.

We looked at the practice's arrangements for safe dental care and treatment. The practice had not implemented the safer sharps' system. We found that needle guards were not routinely used by the dentists. A sharps risk assessment had been undertaken; this was not adequate in addressing the risks presented by using traditional sharps. The documentation made reference to staff being immunised against Hepatitis B and that their response to the vaccine was checked.

We were not provided with evidence to show that one of the dentists and one of the nurses had their immunity levels recorded on file. A risk assessment for these staff had not been undertaken and therefore suitable measures were not in place to mitigate associated risks. Following our inspection, the provider told us that they had taken action to obtain Hepatitis B immunity information. The provider also told us that they were making enquiries with a company regarding using a safer sharps system, which would be implemented in due course.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year.

Emergency equipment and most medicines were available as described in recognised guidance. We found that midazolam was not held in the required dose and was in injectable form that was required to be administered into the patients mouth. We noted that the provider took immediate action to rectify this to ensure guidance was complied with. Staff kept records of their checks to make sure medicines and equipment were available, within their expiry date, and in working order.

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

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The practice used Time, Steam and Temperature (TST) control strips and a data logger. The information obtained from the data logger was not downloaded frequently; we were told this was every two months. This meant its informative value was diminished.

The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.

We found that some hand pieces were stored loosely and uncovered in drawers in the treatment room. This presented a risk of contamination. The provider told us after the inspection that daily use instruments were bagged.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The latest risk assessment had been undertaken on 14 November 2018; actions/recommendations were in progress at the time of our inspection. Prior to the latest risk assessment, this was last undertaken in 2014. The provider told us they had undertaken their own risk assessment in between. Records of water testing and dental unit water line management were in place.

The practice utilised a cleaner to maintain the general areas of the premises. We found that the premises were clean when we inspected.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted that whilst the external bin was locked, it required securing to a fixed object to prevent unauthorised removal. Following our inspection, the provider told us that they had chained the bin to a wall.

Are services safe?

The practice carried out infection prevention and control audits twice a year. The latest audit in July 2018 did not have an overall score, but contained learning outcomes.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. The practice used a paper record system and handwritten notes were made by clinicians.

We looked at a sample of dental care records and noted that individual records were not always written and managed in a way that kept patients safe. For example, dental care records we saw were not always legible. There was scope to improve dental record keeping overall and include greater detail regarding consent and oral cancer risk assessment. We noted that records were kept securely. We were told that staff had completed General Data Protection Regulation training. (GDPR) (formerly known as the Data Protection Act) and had taken appropriate steps. The practice's policy on data protection required update to include information and reference to GDPR.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. We were informed that medicines not required (except for midazolam) would be disposed of into sharps boxes. This was not the correct form of disposal for medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The practice stored NHS prescriptions securely as described in current guidance. Whilst a record was maintained of the first and last number of the prescriptions in a pad, this system would not identify if an individual script was taken inappropriately. The provider contacted us after the inspection to advise that a log had now been implemented.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety and lessons learned and improvements

The practice had risk assessments in relation to safety issues; although we noted that some assessments required review. For example, the sharps risk assessment was not robust and had not identified that needle guards were not always used when sharps were handled.

We noted that an accident had been reported in December 2017; this involved a needle stick injury with the trainee dental nurse. Whilst the documentation did not include any learning points, we saw that a practice meeting was held in January 2018 where the use of needle shields and sharps injuries were discussed. We found that the practice had not taken all reasonable steps to manage the risk of sharps injuries from occurring.

The practice utilised a cleaner to maintain the general areas of the practice. We identified that a lone workers risk assessment had not been completed for this individual.

There was policy and process to help support learning and make improvements when things went wrong. We found that when issues arose, there was scope to improve detailed recording of information.

The practice had a safety incident reporting policy and a significant incidents reporting policy. We noted a significant incident was reported and discussed amongst staff in October 2018. This involved a patient seizure. We discussed the incident with the provider. Whilst the incident was responded to by the staff involved, we were not provided with any written documentation to show an analysis of the event and any learning outcomes for staff as a result. We noted positive actions had been taken at the time of the incident, particularly by one of the dental nurses involved.

There was a system for receiving and acting on safety alerts. The provider received alerts directly from NHS England but not through www.gov.uk website that distributed drug and device alerts. Whilst the provider showed an awareness of alerts issued, a log was not maintained to show any review or action taken in response. Following the inspection, the provider told us that they had signed up to receive the alerts directly.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice systems for keeping dental practitioners up to date with current evidence-based practice required review.

We looked at a sample of 28 patient records. We found that not all clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. For example, X-rays were not always graded and further detail was required in dental record keeping to show that patients' individual needs and preferences were established.

Helping patients to live healthier lives

Our review of a sample of records and discussions held with the dentists supported that the practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

We noted that there was scope to improve the range of health promotion leaflets provided to help patients with their oral health; this was limited in the reception waiting area.

The practice was aware of national oral health campaigns available in supporting patients to live healthier lives. The practice told us they participated in the 'Stoptober' campaign to encourage patients to stop smoking. The dentists referred patients for smoking cessation to their local GP.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice and taking plaque and gum bleeding scores. We looked at a sample of patients' records for two of the dentists and found mixed detail in information recorded. For example, whilst we saw evidence that Basic Periodontal Examination (BPE) was carried by one of the dentists, we did not see that it was always recorded in another dentist's notes. We did not find any evidence of detailed pocket charting recorded in the sample we looked at. Therefore, information available in the records did not support that patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce any home care preventative advice given.

Consent to care and treatment

We looked at how the practice obtained consent to care and treatment and whether this was in line with legislation and guidance.

The practice team told us they understood the importance of obtaining patients' consent to treatment. We noted that FP17 forms signed by the patient supported that consent had been obtained. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. We were informed that costs were also discussed with patients. We found there was insufficient detail in the sample of records that we looked at to support that informed consent had routinely been obtained. This included for example, advantages and disadvantages of treatments, risks and benefits and reasonable expectations of outcomes of each care and treatment option.

The dentists told us that they planned to move to an electronic patient record system and the use of templates would therefore improve overall recording in patient notes.

Patients confirmed in some of the CQC comment cards that the dentist listened to them and gave them clear information about their treatment. One comment included that the dentist was very thorough and explained everything.

The practice's consent policy included information about the Mental Capacity Act 2005. One of the dentists we spoke with positively demonstrated their understanding of the Act. We found that there was scope to improve the practice team's understanding of their responsibilities when treating adults who may not be able to make informed decisions.

The consent policy did not make reference to Gillick competence, by which a child under the age of 16 years of age can give consent for themselves. Staff showed awareness of the need to consider this when treating young people under 16 years of age. After our inspection, the provider told us they had amended their policy to include this information.

Are services effective?

(for example, treatment is effective)

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

Monitoring care and treatment

We found that dental care records contained information about patient's medical histories and past treatment. We did not find that their current needs were always recorded. For example, risk assessments for caries, oral cancer and periodontal condition. We noted that one patient record we looked at contained information regarding oral cancer risk. The lack of detail did not provide assurance that patients' treatment needs were always assessed in line with recognised guidance. We noted that an oral cancer risk audit had been undertaken (April 2018) and had identified that oral cancer risks had not been recorded.

We were advised that the practice did not have a monitor to view X-ray images. This equipment may assist the clinician in making a diagnosis or identifying any abnormalities.

We saw the practice audited patients' dental care records; this required improvement as it had not identified issues we found on the day of our inspection.

Effective staffing

The practice employed a trainee dental nurse who was supported by staff within the practice. They demonstrated their effective skills and knowledge gained since starting in post.

Staff new to the practice had a period of induction based on a structured programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs at annual appraisals. We saw evidence of some completed appraisals and how the practice addressed the training requirements of staff. We were informed that the trained dental nurse was hoping to undertake courses in oral health and fluoride application. One of the principal dentists told us they were planning to undertake an orthodontics course.

Co-ordinating care and treatment

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

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were caring, helpful and respectful. We saw that staff treated patients appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding; one comment included that a patient was seen quickly when needed.

New patients could choose which dentist they wanted to be treated by.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting area provided limited privacy when reception staff were dealing with patients. There was a line on the floor in front of the reception desk for patients to stand behind; this offered some privacy to a patient speaking at the desk. If a patient asked for more privacy they could be taken into another room. Staff did not leave patients' personal information where other patients might see it. They stored paper records securely.

Involving people in decisions about care and treatment

We asked staff about how they helped patients be involved in decisions about their care and how they complied with the requirements under the Equality Act/Accessible Information Standard. (A requirement to make sure that patients and their carers can access and understand the information they are given.)

- Staff were not aware of access to interpreter services for patients who did not have English as a first language. We were informed that these patients would be advised to bring a family member with them to assist. This may present a risk of miscommunications / misunderstandings between staff and patients. Practice staff spoke other languages including Gujarati and Hindi; they could assist patients who spoke these languages. This was included in the practice's information leaflet. Following our visit, the provider obtained access to an interpreter service.
- The practice did not have access to information in different formats/texts to aid communications.

The practice gave patients information to help them make informed choices about their treatment. Patients confirmed that staff listened to them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included verbal information, oral health instructions and post-operative instructions following a procedure.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of some patients needs and preferences.

Staff told us they understood the emotional support needed by patients when delivering care. We were told that longer appointments could be allocated for those who were anxious or nervous.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. The practice was in a bungalow and there was a bell at the front entrance for those with mobility problems to use. This alerted reception staff to provide assistance.

The practice had made some reasonable adjustments for patients with disabilities. These included step free access and a toilet facility with a hand rail but not a call bell. The practice did not have a hearing loop or a magnifying glass/ reading glasses at reception. We were told that a hearing loop was installed after our visit.

A member of the team told us they aided a patient who was blind; this involved helping them whilst inside the practice including form completion.

Staff telephoned or sent a text message to patients a day before their appointment to remind them to attend.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs. Patients commented about the flexibility offered by the practice to accommodate appointments at convenient times for them.

The practice displayed its opening hours in the premises and included it in their information leaflet.

The practice had an efficient appointment system to respond to patients' needs. We were told that the next routine appointment was available within a few weeks' time. Patients who requested an urgent appointment were seen the same day. Patients had enough time during their appointment and did not feel rushed. Appointments appeared to run smoothly on the day of the inspection and patients were not kept waiting.

NHS patients were advised to contact NHS 111 outside of usual opening hours if they had a dental emergency. The practices' information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily.

Listening and learning from concerns and complaints

The practice told us they would take complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint; this advised contact with the practice manager and not the principal dentists who were the leads for complaints.

Staff knew to tell the principal dentists about any formal or informal comments or concerns straight away to enable patients to receive a quick response.

The principal dentists aimed to settle complaints in-house and told us they would invite patients to speak with them in person to discuss these, if any were received. Information was not sufficiently available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns. Information posted in the reception area did not include contact information for external organisations that may be able to assist a complainant.

The practice told us that they had not received any complaints within the previous 12 months.

Are services well-led?

Our findings

Leadership capacity and capability

The dentists had the capacity and skills to deliver high-quality, sustainable care; improvements were also required. Following our visit, the leaders demonstrated a proactive approach to rectify shortfalls we identified.

The team were knowledgeable about issues and priorities relating to the quality and future of services. The leaders had plans for refurbishing and updating the premises. They also had plans to move to an electronic patient record system.

Leaders at all levels were visible and approachable. They worked closely with staff.

The practice had processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The practice was family run and two of the dentists shared administrative functions between them. One of the dentists had plans to retire and discussions had taken place regarding planning for this.

Vision and strategy

There was a vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.

Culture

Staff stated they felt respected and supported. They were proud to work in the practice.

Openness and honesty were demonstrated when responding to incidents. We found that recording systems required strengthening; this may result in greater transparency. For example, a significant event did not include any detailed analysis or evidence of learning outcomes for staff.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff were able to raise concerns or issues and felt able to do so.

Governance and management

The principal dentists had overall responsibility for the management and clinical leadership of the practice. The principal dentists were also responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

There were responsibilities and roles to support governance and management. We found that greater management oversight was required to ensure staff training was updated, for example safeguarding.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. We identified that some policies required review to ensure they were specific to the practice, for example inaccurate references to a practice manager. The whistleblowing policy contained some irrelevant contact information and the consent policy did not include reference to Gillick competence.

There were some effective processes for managing risks, issues and performance. We also identified areas that required improvement such as responding to the risks presented by sharps injuries. Our review of records relating to a staff accident did not show that preventative measures were effectively deployed as a result.

Appropriate and accurate information

The practice did not demonstrate that it had always acted on appropriate and accurate information. For example, the practice did not demonstrate that it complied with its own risk assessment in relation to sharps.

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

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support quality sustainable services.

The practice used patient surveys and verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from patients, that the practice had acted on. For example, patients had requested a card payment system; this was currently being set up at the time of our inspection.

We looked at feedback left on the NHS Choices website. We noted two reviews left. One review was very positive and

Are services well-led?

referred to the flexibility offered by the practice; the reviewer stated they still travelled to the practice whilst living further away. A second review left was negative and referred to treatment that they stated they received which was not effective. The practice had not responded to feedback left on the site.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

The practice gathered feedback from staff through meetings and informal discussions. Staff felt able to offer suggestions for improvements to the service and said they thought these would be listened to and acted on, if any were made.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement; we found systems required strengthening and greater oversight.

The practice did not have adequate quality assurance processes to encourage learning and continuous improvement. Audits included dental care records, radiographs, oral cancer risk and infection prevention and control. The practice could not be assured that audits were always effective; they had not identified all the issues we had found on the day of inspection. When lack of recording of oral cancer risk was identified in the practice, action plans were not effective in addressing the issues raised in an expeditious way.

Staff had annual appraisals. They discussed learning needs and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

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 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must- a) be appropriate b) meet their needs, and c) reflect their preferences • Patients' dental assessments were not completed in accordance with nationally recognised evidence-based guidance. • Patients' dental assessments did not include information regarding the consent process. • Not all staff had a clear understanding of the Mental Capacity Act 2005 and how this might impact on treatment decisions. Reg 9 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to ensure that the regulated activities at C M Desai Ltd - Thurncourt were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were limited systems or processes established to enable the registered person to assess, monitor and improve the quality and safety of services provided. In particular:

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Requirement notices

- Whilst policy and procedures were in place for significant event and accident reporting, the practice did not demonstrate effective learning outcomes from incidents reported.
- There were limited systems for monitoring and improving quality. For example, audits for oral cancer risk and record keeping had not resulted in learning and improvements to the service.
- Policies required review and update to ensure they included relevant information and was specific to the practice.

There were limited systems or processes established to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The provider had not implemented a robust system for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).
- Risk assessments were ineffective in relation to mitigating the risk to sharp injuries.

There were limited systems and processes established to enable the registered person to maintain an accurate, complete and contemporaneous record in respect of each service user. In particular:

- Not all patient records were legible.

Reg 17 (1) (2) (a)(b)(c)