Dr. Graham Best

Corner House Dental Practice

Inspection Report

24 Norwich Road, Cromer, Norfolk
NR27 0AX
Tel: 01263 512390
Website: www.cornerhousedp.co.uk

Date of inspection visit: 16 August 2016
Date of publication: 15/09/2016

Overall summary

We carried out an announced comprehensive inspection on 16 August 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

Corner House Dental Practice is a large and well-established practice that provides mostly private treatment to adults and children. **There are five dentists, two hygienists and nine dental nurses who** are supported by appropriate numbers of administrative staff. The practice has six dental treatment rooms, a staff room, a large reception area and two separate waiting areas.

The practice is open from 8.30am to 5.00pm**Monday to Fridays.**

Before the inspection we sent comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 24 patients, which provided a positive view of the practice and its staff.

Our key findings were:

- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, responding to medical emergencies and managing radiographs.
- There was an effective system in place for reporting and recording significant events.
- There were robust arrangements for identifying, recording and managing risks and implementing mitigating actions.
- Recruitment procedures were robust and ensured only suitable staff were employed.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There were sufficient numbers of suitably qualified and competent staff. Members of the dental team were up-to-date with their continuing professional development and supported to meet the requirements of their professional registration.
- The practice listened to its patients and staff and acted upon their feedback.
- Although the practice regularly undertook a range audits, shortfalls identified by them had not been addressed for long periods of time.

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

- Review the storage of dental care products and medicines requiring refrigeration and ensure fridge temperatures are monitored and recorded.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices, The Health, and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review appraisal protocols to ensure that all staff working at the practice have their performance monitored and assessed.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the practice's protocols in relation to clinical records and ensure that patient recalls are recorded giving due regard to National Institute for Health and Care Excellence (NICE) guidelines
- Review basic periodontal examination scoring to ensure it is consistent across the practice and in line with guidelines issued by the British Periodontal Society's recommendations
- Review the practice's protocols for recording in the patients' dental care records quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000.

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 took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. Staff had received safeguarding training and were aware of their responsibilities regarding the protection children and vulnerable adults. There were sufficient numbers of suitably qualified staff working at the practice and recruitment procedures ensured only appropriated staff were employed. Equipment was well maintained. However the practice's infection control procedures did not meet best practice as recommended by national guidance.

Are services effective?

No action

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

Staff had the skills, knowledge and experience to deliver effective care and treatment. The dental care provided was evidence based and focussed on the needs of the patients. The practice mostly used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. However we noted some inconsistency in the quality of dental care records between dentists, and not all dentists consistently followed recommendations set by the British Periodontal Society for examinations, or NICE guidance for patients' recall frequencies.

Health promotion was good and patients were actively encouraged to maintain good oral hygiene

Are services caring?

No action

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

We collected 24 completed patient comment cards and obtained the views of a further four patients on the day of our visit. These provided a very positive view of the service and the staff. Patients commented on friendliness and helpfulness of the staff and told us dentists were good at explaining their treatment. Staff provided us with specific examples of where they had gone beyond the call of duty to support and care for patients.

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 had good facilities and was well equipped to treat patients and meet their needs. Routine dental appointments were readily available, as were urgent on the day appointment slots and patients told us it was easy to get an appointment with the practice. Good information

Summary of findings

was available for patients both in the practice's leaflet and on the provider's web site. The practice had made adjustments to accommodate patients with a disability. Information about how to complain was available and the practice responded in a timely, empathetic and appropriate way to issues raised by patients.	
Are services well-led? We found that this practice was providing well-led care in accordance with the relevant regulations. There was a clear leadership structure and staff were aware of their responsibilities .The practice had a number of policies and procedures to govern its activity and held regular staff and partners' meetings. Feedback from staff and patients was actively used to improve the service provided, and we were given many examples where managers had implemented their suggestions. However, the provider had failed to address known shortfalls identified by its infection control and records' audits and did not have a meaningful plan in place to achieve best practice in its decontamination process.	**No action**

Corner House Dental Practice

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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was carried out on 16 August 2016 by a CQC inspector who was supported by a specialist dental adviser. During the inspection, we spoke with three dentists, two dental nurses, the practice manager and a member of reception staff. We reviewed policies, procedures and other documents relating to the management of the service. We received feedback from 28 patients about the quality of the service, which included comment cards and patients we spoke with during our 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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice had a policy for reporting and managing any significant events and a specific register of events was kept. Any events were reported to one of the practice mangers and a specific significant events form was completed. Patient safety events were a standing agenda at the staff monthly meetings, so that learning from them could be shared across the practice. We viewed paperwork in relation to recent events concerning x-rays being saved onto the wrong patients' notes, the practice's server crashing and a needle stick injury and noted they had been fully recorded and managed well by practice staff.

Staff we spoke with also had a good understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences).

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. Records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. One of the dentists was the safeguarding lead and acted as a point of referral should members of staff have safeguarding concerns.

Staff we spoke with demonstrated their awareness of the different types of abuse, and understood the importance of safeguarding issues. Contact details of relevant agencies involved in protecting vulnerable people were available around the practice, making them easily accessible to staff. We noted that the practice's safeguarding policy had been discussed at the staff meeting of August 2016 to remind staff of who the lead was, and of local safeguarding procedures.

The practice had minimised risks in relation to used sharps (needles and other sharp objects, which might be contaminated) by using a sharps' safety system, which allowed staff to discard needles without the need to re-sheath them. Staff spoke knowledgeably about action they would take following a sharps' injury and a sharps' risk assessment had been completed. Only the dentists handled sharps, however we noted that some sharps' bins were stored down in cupboards and not wall mounted at eye level so it was clear when the bin became full and so that sharps could be placed safely in them.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. Patients' notes we viewed demonstrated that the dentists used rubber dams to ensure patient safety. However we noted that rubber dam clamps were not routinely sterilised before use and were stored loose in the kit box.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies found in dental practice. There was an automated external defibrillator and staff had received training in how to use it. Staff had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. Three staff had been trained to administer first aid if needed.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. However we noted that the glucagon (a medicine used to treat hypoglycemia) was not kept in a fridge and its expiry date had not been amended in light of this. Checks of the equipment and medicines were undertaken to ensure they were in date, although these were done monthly and not weekly as recommended by national guidance. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. However, staff did not regularly rehearse emergency medical simulations so that they could keep their skills up to date.

Staff recruitment

All the partners and the practice managers were involved in the recruitment of new staff. We reviewed personnel records and found that appropriate recruitment checks

had been undertaken for staff prior to their employment. For example, proof of their identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). Both clinical and non-clinical had received a DBS disclosure check to ensure they were suitable to work with children and vulnerable adults. Interview notes were kept and a standard list of questions was used to ensure consistency and fairness in the recruitment procedure.

Detailed job descriptions were available for all roles within the practice and all staff underwent a thorough induction to their role.

Monitoring health & safety and responding to risks

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. The risk assessments we viewed were thorough and covered wide range of identified hazards in the practice and the control measures that had been put in place to reduce the risks to patients and staff. Both practice managers had undertaken specific training in risk management and reviewed all the assessments each year to ensure they were still relevant for the practice.

A legionella risk assessment had been carried out in June 2015 and water temperatures were monitored monthly to ensure they were at the correct level. Regular flushing of the water lines and dip slide testing was carried out in accordance with current guidelines to reduce the risk of legionella bacteria forming.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for all products used within the practice, although data sheets no longer relevant needed to be archived.

A fire risk assessment had been completed in June 2016 and fire detection and firefighting equipment such as extinguishers and emergency lighting were regularly tested, evidence of which we viewed**.** Regular fire evacuation drills were completed, although these did not include patients so it was no clear how the practice would manage in a fire when patients were present.

We noted that there was good signage throughout the premises clearly indicating low ceilings, fire exits, the use of x-ray machines and compressed gas, and who the first aiders were to ensure that patients and staff were protected.

The practice had a comprehensive business continuity plan in place for major incidents such as the loss of utilities or natural disasters, a copy of which was kept off site electronically.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting areas, staff room, stairways and corridors. We checked three treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. However, we noted that one surgery was cluttered and contained a wooden chest and some pictures that could not be cleaned easily. Some sinks had plugs and overflow outlets and one sink was too small to accommodate two separate bowls so that instruments could be cleaned appropriately. Not all surgeries had coved flooring and not all bins were foot operated. Some cleaning equipment was not stored according to guidance. We checked treatment room drawers and noted a number of instruments that had not been pouched but left loose and uncovered. These were within the splatter zone, and therefore risked becoming contaminated over time.

The practice did not have a separate decontamination room for the processing of dirty instruments, so all instruments were cleaned in the treatment room. The dental nurse used a system of manual scrubbing for the initial cleaning process. Following inspection instruments were placed in an autoclave (a device used to sterilise medical and dental instruments). When instruments had been sterilized, they were pouched and stored until required. The dental nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health, although the external yellow clinical waste bin was

Are services safe?

not secured to a wall and was easily accessible to the public. The practice used an appropriate contractor to remove clinical waste from the practice and waste consignment notices were available for inspection.

Staff uniforms were clean and their arms were bare below the elbows to reduce the risk of cross infection. However, the dentist did not change into different trousers when treating patients, thereby compromising good infection control. We saw both the dentist and dental nurse wore appropriate personal protective equipment including masks and eyewear during the consultation we observed. The patient was also given eye protection to wear. Following the consultation, we saw that the dental nurse wiped down all areas where there had been patient contact.

Records showed that all dental staff had received training in infection control and had been immunised against Hepatitis B. We noted that the lead infection control nurse had demonstrated hand hygiene procedures to staff at a meeting in June 2016.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. Portable appliance testing had been undertaken in October 2015. Staff told us they had enough equipment for their works and that any repairs were undertaken quickly. Appropriate equipment was available to deal safely with bodily fluid and mercury spills.

Stock control was good and medical consumables we checked were within date for safe use. However, we noted that the temperature of the fridge used to store temperature sensitive consumables was not monitored to ensure it was at the correct level.

Our review of dental care records showed that the batch numbers and expiry dates for local anaesthetics and antibiotics given to patients were always recorded. However prescription numbers were not recorded in the notes once issued so they could be tracked effectively. We also noted that high concentrated fluoride toothpaste was not properly prescribed for private patients. No patient group directions were available to the dental hygienists to allow them to administer medicines in line with legislation

There was a system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IR (ME) R).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs and a copy of the local rules. Training records showed relevant staff had received training for core radiological knowledge under IR(ME)R 2000 Regulations. Rectangular collimation was used to confine x-ray beams. Dental care records we reviewed showed some inconsistency between dentists in the recording and grading of x-rays in line with FGDP guidance.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with four patients during our inspection and received 24 comments cards that had been completed by patients prior to our inspection. All the comments received reflected that patients were very satisfied with the quality of their dental treatment and the staff who provided it.

Our discussion with the dentists and review of nine sets of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines for wisdom tooth removal and antibiotic prophylaxis. However, some records showed that NICE guidance was not being followed for patients' recall frequency, and that basic periodontal examination scoring and pocket charting needed to be more consistent with the British Periodontal Society's guidelines

We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping, the quality of dental radiographs and infection control.

Health promotion & prevention

A number of oral health care products were available for sale to patients including interdental brushes, mouthwash and floss. Dental care records we reviewed demonstrated dentists had given oral health advice to patients and referrals to other dental health professionals were made if appropriate. Patients were asked about their smoking and alcohol intake as part of their medical history and there was information about NHS stop smoking services in the patient waiting areas. During our observation we noted that the dentist discussed the increased risk of oral cancer with one patient who smoked.

One dental nurse had recently completed an oral hygiene educator course and was keen to put her training into practice. For example, she told us she planned to visit a local home for older people to increase care staff's awareness of residents' oral hygiene and she also wanted to visit local schools. She had recently created a display in the waiting room highlighting how many sugar cubes were contained in a range of fizzy drinks. The practice manager told us that many patients had commented on how shocking the amount of sugar was. Each year the practice participated in 'National Smile Week', a national campaign to promote good oral health.

Staffing

There was a stable and established staff team at the practice, many of whom had worked there for many years. They told us they were enough of them for the smooth running of the practice and a dental nurse always worked with each dentist. An additional nurse was on duty most days who could cover annual leave and sickness if needed. However, the dental hygienist worked alone and without support of a dental nurse. The General Dental Council (GDC) recommends that dental staff are supported by an appropriately trained member of the dental team at all times when treating patients.

Files we viewed demonstrated that staff were appropriately qualified and had current professional validation and professional indemnity insurance. The practice had appropriate Employer's Liability insurance in place. Training records we viewed showed that staff had undertaken a range of essential training such as health and safety; information governance, safeguarding and medical emergencies. One dentist had a special interest in orthodontics, and one nurse had recently completed an Oral Educator Course.

The practice managers conducted all appraisals for the nurse and reception staff. The appraisal covered achievement of objectives, their performance and included a development plan. Appraisal documentation and personal development plans we saw demonstrated a meaningful and comprehensive appraisal process was in place. However, practice managers were not appraised themselves, so it was not clear how their performance was monitored.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves such as conscious sedation or oral surgery. Staff were aware of appropriate referral pathways and referrals we viewed were of good quality and contained the necessary patient information. However we noted that a

No action

Are services effective?

(for example, treatment is effective)

referrals log was not kept so that referrals could be tracked and monitored and patients were not routinely given a copy of their referrals for their information. Referrals to the practice's hygienists were not in writing, and should be.

Consent to care and treatment

Patients told us that they were provided with good information during their consultation and they had the opportunity to ask questions before agreeing to a particular treatment. Dental records we reviewed demonstrated that treatment options, and their potential risks and benefits had been explained to patients. Evidence of their consent had also been recorded.

The practice had a specific patient consent policy in place and training files we viewed showed that staff had also received specific training in the Mental Capacity Act 2005 (MCA).Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA)

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection, we sent comment cards so patients could tell us about their experience of the practice. We collected 24 completed cards and obtained the views of a further four patients on the day of our visit. We received many positive comments about the caring, professional and empathetic nature of staff. Patients were positive about their interactions with staff and said they were treated by them in a way that they liked.

Staff gave us examples where they had gone out their way to assist patients. For example, staff had delivered sets of dentures to older patients' homes to save them coming back to the practice; reception staff regularly looked after children whilst their parents had x-rays, and photocopied interesting articles for patients from waiting room magazines. In one instance staff had fast tracked treatment for one young person who was being bullied at school due to their dental problems.

We spent time in the reception area and observed a number of interactions between the receptionists and patients coming into the practice. We noted that reception staff were friendly and helpful to patients, and acknowledged patients' frustrations with the limited parking available due to a local festival.

Staff were aware of the importance of providing patients with privacy and maintaining their confidentiality. For example, we noted that patients' medical history forms had been placed face down on the reception desk. Computer screens at reception were not overlooked and all computers were password protected. Patients sat in a completely separate room to the reception area, allowing for good privacy. All consultations were carried out in the privacy of the treatment rooms and we noted that doors were closed during procedures to protect patients' privacy.

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Information leaflets were easily available in the practice on a range of issues including how to manage a dry mouth, bad breath, missing teeth and geographic tongue erosion to increase patients' understanding of treatment.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

In addition to general dentistry, the practice offered a number of cosmetic treatments, orthodontics and two direct access hygienists who could see patients without the need for a referral from the dentist. A dental technician was also based on the premises and was able to provide same day repairs for patients.

Patients had access to a helpful website which provided information on the range services offered, the dental team, and the practice's opening hours and treatment costs. We also found good information about private charges in the practice's information leaflet to ensure patients knew how much their treatment would cost.

Patients were able to make an appointment by phone, email or in person and could sign up for text reminders of their appointments. The practice was open Monday to Friday from 8.30am to 5pm and each dentist had a number of emergency appointment slots for urgent treatment. If patients were unable to see their usual dentist, they were able to see another in the practice. One dentist was on call each weekday evening and the practice worked jointly with another local practice to provide weekend cover. The practice also opened occasionally on a Saturday morning by appointment to meet patients' needs. Patients we spoke with were satisfied with the appointments' system and told us that getting through on the phone was easy.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for and had undertaken a disability access audit in June 2016. There were level access treatment rooms on the ground floor for those patients with limited mobility as well as parents and carers using prams and pushchairs. There was also a ground floor disabled friendly toilet and a hearing induction loop was available. However, there were no easy riser chairs, or wide seating available in the waiting area to accommodate patients with mobility needs, or practice information in other formats such as large print, braille or audio, despite the practice's older population group.

Concerns & complaints

We viewed the practice's complaints' policy, which clearly outlined the procedure for patients, along with the timescales involved and the details of external organisations that patients could contact if unhappy with their treatment. Information about how to raise concerns was also available in the practice information leaflet, but not in either of the two waiting areas where patients would most likely be able to see it.

We viewed the paperwork in relation to two recent complaints received by the practice and found they had been dealt with professionally and empathetically. Complaints were a standing agenda item at the monthly practice meeting so that learning from them could be shared.

No action

Are services well-led?

Our findings

Governance arrangements

There was an established leadership structure within the practice with clear allocation of responsibilities amongst the staff. For example, there were two practice managers, and specific leads for infection control, information governance and safeguarding. Staff we spoke with were all clear about their own roles and responsibilities. Both the practice managers held formal management qualifications and we found the practice manager on the day of our inspection to be skilled, knowledgeable and experienced for her role. We received positive comments about both practice managers from staff.

The practice had a wide-ranging set of policies and procedures in place to govern its activity, which were easily available to staff. We looked at a number of policies and procedures and found that they were up to date and had been reviewed regularly by the practice managers. Staff were required to confirm that they had read and understood them at their induction and any changes in the policies were communicated at staff meetings.

Communication across the practice was structured around monthly practice meetings, which were alternated between a Monday and Thursday to ensure that part-time staff could attend. Staff told us the meetings were useful and provided a good forum for teamwork and communication. In addition to these, were monthly partners' meetings, attended by the two practice managers.

Regular audits were undertaken to assess standards in radiography, infection control and the quality of clinical notes. We also noted a surgery bin audit had been completed in June 2016 to check that waste had been disposed of correctly. However, results were not used to make improvements. For example, in 2014 the infection control audit had identified that some surgery sinks had plugs and overflows, that there was no coved flooring in some surgeries that some work surface joints were not seamless and bins were not foot operated. We looked at the audit for 2016 and found that these same shortfalls had not been addressed and remained outstanding. Patients' records audits had continued to show that some dentists were not recording patients' social histories.

The practice did not have a separate decontamination room, or a robust plan in place to demonstrate how it planned to achieve best practice in its decontamination procedures. It had obtained a number of quotes in 2010 to install a separate decontamination facility, but little action had been taken since then.

We found some inconsistency in practice amongst the dentists. For example, some dentists used pre-generated computer templates for the recording of patients' records; others did not. We noted that records which were templated were of much better quality. One dentist did not wear separate trousers whilst delivering treatment to patients, whilst others wore full scrubs.

The two practice managers did not receive regular appraisals so it was not clear how their performance was monitored, or their training needs identified.

Each year the practice completed an information governance toolkit to ensure it handled patients' information in line with legal requirements. The practice had achieved a score of 88% on its most recent assessment, indicating it to managed patient information in a satisfactory way.

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

The practice encouraged and valued feedback from patients and its staff. For example, all patients were encouraged to complete comments forms which asked them for their views and comments received were read out at staff meetings. The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing and recent figures for July 2016 showed that seven of eight respondents would recommend the practice.

We found good evidence that the practice also listened to patients. For example, patients had commented that waiting room lighting was poor making it difficult to read the magazines and complete their medical history forms. As a result, the practice installed LED lighting. Following patient feedback, new and more comfortable chairs had been purchased in the waiting room, text appointments remainder messages now contained the practice's postcode, toys were made available in one dentist's treatment room to entertain patients' siblings and fee discounts were more clearly stated on treatment plans.

The practice also gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff

No action

Are services well-led?

told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were given examples where managers had listened to staff and implemented their suggestions and ideas. For example, more comfortable chairs were purchased for the staff room, bottled Lucozade was now kept at reception for patients who might faint, appointment scheduling had been reviewed and staff's marketing ideas to promote the hygienists' services had been implemented by the practice managers and partners.

This section is primarily information for the provider

Enforcement actions

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.