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Cromwell Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 6 March 2017 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

Cromwell Dental Practice operates from a converted commercial property and provides a mix of private and NHS dentistry. The practice is situated in the town Walton On Thames, Surrey. The practice has two dental treatment rooms; decontamination of dental instruments is mainly carried out within a designated area of each treatment room with another autoclave housed in a designated space in the kitchen area.

The practice staff consists of a dentist, a receptionist and a dental nurse. The practice also employs two part-time dental hygienists.

The practice opens:

Monday to Friday between 9.00am and 5.30pm.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Before the inspection we sent Care Quality Commission (CQC) comments cards to the practice for patients to complete to tell us about their experience of the practice.

Summary of findings

We collected 19 completed cards. All the comments from patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were systems in place to reduce and minimise the risk and spread of infection. We did note there were areas that could be improved; these are detailed in the main body of the report.
- The practice had safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- There was a system in place for reporting incidents.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice maintained a clinical governance system to underpin the clinical care provided.

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

- Review the practice's risk assessments and ensure sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Consider providing an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance is prepared.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the availability of hearing loops for patients who are hard of hearing.
- Consider implementing a system to account for NHS prescriptions issued by the dentist to prevent inappropriate prescribing or loss of prescriptions.
- Review the practice's protocols for completion of dental records taking into account the guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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.

The practice had effective arrangements for essential areas such as clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We did find that there were some minor areas that could be improved with respect to infection control protocols and procedures. These are detailed in the main body of the report.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action ✓

Are services effective?

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

The dental care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs.

Staff, where appropriate were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

No action ✓

Are services caring?

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

We collected 19 completed Care Quality Commission patient comment cards. These provided a positive view of the service the practice provided. All the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

No action ✓

Are services responsive to people's needs?

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

Patients were able to access treatment within a reasonable time frame and had adequate time scheduled with the dentist to assess their needs and receive treatment. The practice treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice had a complaints procedure that explained to patients the process to follow. The practice followed the correct processes to resolve any complaints.

No action ✓

Summary of findings

Are services well-led?

No action

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

Clinical leadership was provided by practice owner. The staff had an open approach to their work and shared a commitment to continually improving the service they provided.

There was a no blame culture in the practice. The practice had clinical governance and risk management structures in place.

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. Staff were supported to maintain their continuing professional development as required by the GDC.

Staff told us that they felt well supported and could raise any concerns with the practice owner. All the staff we met said that they were happy in their work and the practice was a good place to work.

Cromwell 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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We spoke to all five members of staff, conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records.

We reviewed 19 Care Quality Commission (CQC) comment cards that had been completed by patients in the two weeks prior to our inspection. All the comments were positive.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had an incident reporting system in place along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries to patients and staff. This included RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations).

There was an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE) that affected the dental profession. Where relevant, these alerts were shared with all members of staff by the practice owner.

Reliable safety systems and processes (including safeguarding)

We spoke with the dentist about the prevention of needle stick injuries. They explained that the handling of sharps was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne virus. The practice used a system whereby needles were not manually re-capping using the hands following administration of a local anaesthetic to a patient. The practice used a special metal block to prevent needle stick injuries from occurring during needle re-capping. The dentist was responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The only point of note was that the infection control policy required a written protocol detailing a risk assessment as recommended by the EU directive. The practice owner assured us that this would be carried out as soon as practically possible.

We asked the dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons is recorded in the patient's dental care records giving details as to how the patient's safety was assured. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the CQC. This information was displayed in the reception area. The practice owner acted as the lead for safeguarding and all the staff we spoke with were aware of this. The staff demonstrated they had a good understanding of what they needed to do if they suspected potential abuse.

We saw evidence that staff had completed safeguarding training to the appropriate levels and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues internally with a member of the management team.

Medical emergencies

The practice had arrangements in place to respond to medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment.

The practice had emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. The practice had

Are services safe?

access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and medical oxygen were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies.

Staff recruitment

The practice staff consists of a dentist, a receptionist and a dental nurse. The practice also employs two part-time dental hygienists.

There was a recruitment policy in place and we reviewed the recruitment files for all staff members. We saw that relevant checks to ensure that the person being recruited was safe and competent for the role had been carried out. This included DBS checks (The DBS checks 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) for all members of staff, a check of registration with the General Dental Council (GDC) where appropriate. Although these were not available for inspection, the practice owner assured us they had references, ID checks and employment contracts kept in a secure place off site. All staff were up to date with their Hepatitis B immunisations and records were kept on file.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a system policies and risk assessments for fire safety, general health and safety. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were systems in place to reduce the risk and spread of infection within the practice. We did find that there were some minor areas that could be improved with respect to organisation and décor. For example, we noted that some areas of the practice appeared cluttered. This included the practice owner's treatment room and the kitchen area that contained one of the sterilisers. The stock cupboard which also stored the compressors was in need of redecorating. The practice owner told us they had plans to do this in the summer of 2017 when the practice would close during the holiday period.

The practice had in place an infection control policy that had been reviewed in April 2016 and we saw that they had carried out audits of their procedures in August 2016 and January 2017. These audits showed that the practice was improving and meeting essential quality requirements of HTM 01 05 (national guidance for infection prevention and control in dental practices).

We saw that the two dental treatment rooms, waiting area, reception and toilet were visibly clean. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

Staff we spoke with described the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They explained how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacterium which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in December 2014.

Are services safe?

The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice used designated areas within each treatment room for instrument cleaning, sterilisation and the packaging of processed instruments. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a system of zoning from dirty through to clean.

The practice used a combination of an ultra-sonic cleaning bath and manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in a clean box and transported to the decontamination area where they were placed into an autoclave (a device for sterilising dental and medical instruments). We did note that the practice did not use a temperature gauge to check if the water was below the recommended temperature for manual scrubbing. The practice owner assured us that this would be addressed as soon as practically possible. When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure that the autoclaves and ultra-sonic cleaning baths used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date. The manufacturer's recommended validation test for the ultra-sonic cleaning baths were carried out and the results of which were recorded in an appropriate log file.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines.

The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a locked storage bin at the rear of the practice outside where collection took place by the waste contractor. Waste consignment notices were available for inspection.

We saw environmental cleaning was carried out according to a cleaning plan developed by the practice. We did note that the storage of cleaning equipment could be improved by using wall mounted brackets for example to reduce clutter and the possibility of a trip hazard to members of staff. The practice owner assured us that these points would be addressed as soon as practically possible.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in February 2017. The practices' X-ray machine had been serviced and calibrated as specified under current national regulations in March 2016 and was due to be tested again in March 2019. Portable appliance testing (PAT) had been carried out in January 2015 and new practice compressors had been installed very recently.

The practice also dispensed their own medicines as part of a patients' private dental treatment. These medicines were a range of antibiotics, the dispensing procedures were in accordance with current secondary dispensing guidelines and medicines were stored according to manufacturer's instructions. A satisfactory logging system was in place to account for the medicines dispensed by the practice. We noted that a similar logging system could be introduced for NHS prescriptions to prevent inappropriate prescribing or loss of prescriptions.

Radiography (X-rays)

We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IR(ME)R). This information contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, HSE notification and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

Dental care records showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological protection board (NRPB) guidelines

Are services safe?

and patients and staff were protected from unnecessary exposure to radiation. Training records showed that the dentist had received training for radiological knowledge under IR(ME)R 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options were explained.

Where relevant, preventative dental information was given to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately, although some entries would benefit from increasing the level of detail. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. The practice appointed two dental hygienists to work alongside of the dentist in delivering preventative dental care. The dentist explained that patients at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

Staff told us staffing levels were suitable for the size of the service and they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered all of the recommended topics required for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

Working with other services

The dentist could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery and orthodontic providers. Referrals were managed through an internet based electronic referral system developed by local NHS commissioners. The aim of this system was to ensure that patients were seen by the right person, in the right place and at the right time.

Consent to care and treatment

The dentist explained how they implemented the principles of informed consent; the dentist had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options.

The dentist went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to

Are services effective?

(for example, treatment is effective)

fully understand the implications of their treatment. They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients' clinical records were stored in mainly paper form. Paper records were stored in locked metal filing cabinets to prevent unauthorised access by the public. Computers which contained patient confidential information were password protected and regularly backed up to secure storage.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

The CQC comments cards we received all made positive remarks about the staff's caring and helpful attitude. They all described a very positive view of the service the practice provided. Patients indicated that they felt comfortable and relaxed with their dentist/dental hygienist and that they were made to feel at ease during consultations and treatments. Patients who were nervous about dental treatment indicated that the dentist/dental hygienist was calm, listened to their concerns, and gave them reassurance throughout the processes of the dental treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Patients commented that the whole team were welcoming, professional, caring, respectful and friendly. They were very happy with the quality of treatment provided. During the inspection we observed the general atmosphere in the practice was calm, welcoming and friendly.

All the staff were focussed on a 'patient centred' approach to treating patients. They were aware of the importance of protecting patients' privacy and dignity. We observed that staff always kept the treatment room doors closed when patients were in the room.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. Leaflets were available that detailed the costs of private treatment. The dentist we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The dentist could decide on the length of time needed for their patient's consultation and treatment. The staff we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Staff told us that they could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment.

We asked staff how they would support patients that had difficulty with hearing or vision. They explained how they would face the patient and speak slowly and clearly especially for someone who had hearing difficulties to allow the patient to lip read. Staff told us they would assist a blind patient or any patient who had difficulty with mobility by physically guiding and holding their arm if needed.

The practice had made reasonable provision for patients using wheelchairs although we noted the toilet facilities were not fully accessible. Staff told us they informed patients about these limitations prior to any appointments booked. The practice had a portable ramp they used to assist patients using a wheelchair and when entering the practice there was a level access leading to the reception area, waiting area and the two treatment rooms.

Access to the service

The practice opens Monday to Friday between 9.00am and 5.30pm.

The practice displayed its opening hours on their premises, on the practice website and in the practice information leaflet available in the waiting area.

We asked the staff about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details about how to access out-of-hours emergency treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed on the website, in the reception area and in the practice information leaflet. The staff explained if patients were not happy they would discuss the issues with one of the members of the management team so the problem could be resolved quickly and amicably.

Staff told us any complaints raised were dealt with appropriately by the practice owner and there were team meetings for staff to discuss and learn from.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of the practice owner who was responsible for the day to day running of the practice in conjunction with the practice manager.

The practice maintained a system of policies and procedures. All the staff were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice owner on a regular basis.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in their abilities to address any issues as they arose.

Leadership, openness and transparency

The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be caring and committed to the work they did. Staff appeared motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by a detailed log of completed training and a programme of clinical audit.

The practice carried out several clinical audits, these included infection control and X-ray quality. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

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

The practice gathered feedback from patients on an ongoing basis through the Friends and Family test left in the waiting area. They reviewed responses and comments as they came in. Patients commented; they would recommend the practice to friends and family, the practice was clean, dental team were very friendly and professional.

Staff told us that the management team were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.