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TOOTHism Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 24 September 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice is one of two dental practices owned by the principal dentist with both registered separately with the Care Quality Commission (CQC). The practice was founded in June 2010 by the principal dentist. The premises consist of two treatment rooms and one dedicated decontamination room. There are public and staff toilet facilities, a waiting room and separate reception area, an administrative office and staff kitchen.

The practice provides private dental services and treats both adults and children. There are approximately 1,300 registered patients. The practice offers a range of dental services including veneers, crowns and bridges, oral hygiene and fissure sealants.

The service is provided by two dentists one of whom is the principal, two dental hygiene therapists, a dental nurse and a receptionist. A trainee dental nurse has recently been employed by the practice who is due to replace the current dental nurse who is taking on an administration role from 1October 2015. The practice is open from 9:00 am to 6.00 Monday, Tuesday, Wednesday and Friday; from 9.00 am to 7.00 pm on Thursday and from 9.00 am to 2.00 pm on Saturday. The practice is closed for lunch between 1.00 pm and 2.00 pm Monday to Friday.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We carried out an announced, comprehensive inspection on 24 September 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We received 28 CQC comment cards completed by patients who all commented positively about the staff and the care they received from the practice. We reviewed patient feedback gathered by the practice over the last 12 months.

Our key findings were:

- The practice had systems to assess and manage risks to patients and staff, including for infection prevention and control, health and safety and the management of medical emergencies. The practice however did not have an automated external defibrillator (AED)
- Equipment, such as the autoclave (steriliser), fire extinguishers and oxygen cylinder were checked for effectiveness and were regularly serviced.
- Dental care records were well maintained and patients were referred for specialist treatment in a timely way.
- Patients said they felt the practice offered an excellent service and that the whole dental team were professional, caring, respectful and friendly.
- The practice had a clear vision for the services it provided and staff told us they were well supported by the management team.
- There was evidence that the practice audited many areas of their practice as part of a system of improvement and learning.

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

Review staff awareness of Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities as it relates to their role.

Monitor and record the fridge temperature to ensure that medicines were being stored in line with the manufacturer's guidance.

Review current protocols to ensure personnel records for all staff are appropriately maintained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There was an effective system in place for reporting and learning from incidents. There were policies and procedures in place for child protection and safeguarding adults and staff had received safeguarding training.

There were processes in place which staff followed for the management of infection control in line with national guidance. There were arrangements for managing medical emergencies including access to emergency medicines and emergency medical equipment.

Sufficient quantities of equipment were in use at the practice and they were serviced and checked for effectiveness at regular intervals. The practice kept a well maintained radiation protection file and x-ray equipment was regularly serviced.

Are services effective?

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

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE). The practice focused on preventative care and supported patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit

Patients received an assessment of their dental needs including taking or updating a medical history at each visit. Patients were referred to other services in a timely manner if needed. Explanations were given to patients in a way they understood and treatment risks, benefits, options and costs were explained.

Staff were supported through training, appraisals and opportunities. Staff had not received formal training in the Mental Capacity Act 2005 but understood the general principles of the Act. Staff were aware of Gillick competency but they were not fully familiar in its implications and had not received training on the subject.

Are services caring?

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

We collected feedback from 28 patients all of which described a very positive view of the service the practice provided. They reported that staff treated them with dignity and respect and maintained their privacy.

The practice provided patients with information to enable them to make informed choices about their dental care and treatment. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the information given by staff.

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 quickly in an emergency, and there were arrangements in place for patients to receive alternative emergency treatment when the practice was closed.

The treatment rooms, waiting room and patient toilet were all located on the ground floor and were accessible to patients who had restricted mobility

Summary of findings

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures provided staff with guidance on how to support patients who wanted to make a complaint. There had been no complaints recorded in the last year.

Are services well-led?

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

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. There was a full range of policies and procedures in use at the practice which were regularly reviewed and kept up to date as protocols or guidance changed.

There were weekly informal practice meetings as well formal staff meetings every two to four weeks with detailed minutes and action points from them recorded.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning. Patient satisfaction surveys were regularly undertaken and results monitored to identify trends.

TOOTHism Dental Clinic

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 24 September 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and checked dental care records to confirm our findings. We spoke with two dentists and the dental nurse. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We dental decontamination procedures of dental instruments.

We reviewed 28 Care Quality Commission (CQC) comment cards completed by patients prior to our inspection and reviewed patient feedback gathered by the practice over the last 12 months.

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

There was an effective system in place for reporting and learning from incidents. There was a policy for staff to follow for the reporting and documentation of safety incidents and a learning process in place in which any incidents that occurred were discussed at staff meetings. No incidents had been reported in the last year. Staff explained patients would be told when they were affected by something that goes wrong, provided with an apology and informed of any actions taken as a result.

Alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and the NHS Central Alert System (CAS) were currently received through the sister practice and disseminated to staff at this practice. However the principal dentist said that both practices would be registered to separately receive any alerts. (MHRA and CAS alerts identify any problems or concerns relating to a medicine or piece of medical equipment, including those used in dentistry).

Staff were provided with guidance on what to do in the event of experiencing a sharps injury during the course of their work. There were robust contaminated needle-stick injury protocols involving advice and assessment from occupational health at a local teaching hospital.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies. Staff had received safeguarding training and were able to describe the signs they would look out for which may indicate abuse or neglect. There had been no safeguarding issues that had required to be reported by the practice to the local safeguarding team.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. The practice had a business continuity plan in place to ensure continuity of care in the event that the practice's premises could not be used for any reason. Rubber dams were used when completing root canal treatments in line with guidelines from the British Endodontic Society. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.]

Medical emergencies

There were arrangements in place to deal with medical emergencies. Staff received annual training in basic life support and this was last updated in September 2015. The practice planned to introduce regular scenario training to keep staff familiarised with medical emergency procedures.

The practice held emergency medicines in line with guidance issued by the British National Formulary (BNF) for dealing with common medical emergencies in a dental practice. These medicines were in date and fit for use. A log of medicines' expiry date was kept and checked monthly. Emergency equipment was available including portable oxygen and breathing aid masks and these were checked weekly and logged. However, the practice did not have an automated external defibrillator as recommended by the Resuscitation Council (UK) but were currently sourcing one to purchase. (An AED is a portable electronic device that analyses life-threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Staff recruitment

There was a recruitment protocol in place that described the process when employing new staff, to ensure that they were suitable and competent for the role. This included checking proof of identity, skills and qualifications, and registration with the General Dental Council (GDC). (The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians). Copies of GDC registrations for staff were made available for us to view. Criminal records checks through the Disclosure and Barring Service (DBS) had been undertaken for all staff and references were sought before staff commenced employment. New staff were subject to a three month probationary period which included supervisory support and assessment.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire in April 2015 and fire extinguishers were next due to be serviced in May 2016. There were arrangements in place to

Are services safe?

meet the Control of Substances Hazardous to Health (COSHH) 2002 regulations. (COSHH 2002 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).The practice maintained a comprehensive COSHH file with full detail of all original product documents along with actions to minimise risk recorded. Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. This was demonstrated through direct observation of the daily cleaning processes undertaken and a review of the protocols the practice followed which were in line with Department of Health (DoH) Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05). The practice carried out infection control audits twice yearly and the last one had been completed in June 2015 which demonstrated 98% compliance.

We observed that the dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Hand washing facilities including liquid soap and paper towels were available in the clinical areas and public toilets. The dental nurse was the infection control lead who described to us the end-to-end process of infection control procedures at the practice. There were excellent routines and written protocols for treatment rooms set up and shut down.

The practice had a single decontamination room that connected to both treatment rooms for instrument processing. The dental nurse demonstrated the process followed from taking dirty instruments through to clean and ready for use again. There was a good system for the transporting of dirty instruments, manual cleaning and inspection under an illuminated magnifier. This was followed by autoclave sterilisation with vacuum and non-vacuum cycles. All instruments were pouched following sterilisation or pre-pouched during the vacuum cycle. The practice had systems in place for daily quality testing of the autoclave and we saw records which confirmed that these had taken place.

Records showed a risk assessment for Legionella had been carried out in April 2013 by an external environmental company. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). This process identified low risks. The practice demonstrated that they had acted on the report recommendations to minimise the risks. For example, they demonstrated the testing and recording of hot and cold water temperatures on a monthly basis and bi-annual testing of the mains water supply. Dental unit water lines (DUWL) were maintained to prevent the growth and spread of legionella. The method described by the dental nurse for flushing (DUWL) was in line with HTM 01-05 guidelines.

Dental waste was segregated, stored and disposed of in accordance with the Department of Health (DoH) Health Technical Memorandum 07-01;Safe management of healthcare waste (HTM 07-01). Sharps containers were appropriately positioned and waste was separated and removed from the practice by a reputable carrier. Waste consignment notes were available for inspection.

Environmental cleaning was carried out in house by the dental nurse who had a separate cleaning employment contract. There was a schedule of daily cleaning tasks and a big clean was undertaken weekly. We observed that cleaning equipment took into account national guidance on colour coding to prevent the risk and spread of infection. We observed that storage of some cleaning items could be improved which were addressed by the practice immediately.

Equipment and medicines

Sufficient quantities of equipment were in use at the practice and they were serviced at regular intervals. The practice maintained a comprehensive record of all equipment including service and maintenance review dates. There were records to demonstrate that the autoclaves for sterilising dental equipment and the compressor for use in dental procedures were serviced annually and were last checked in February 2015 and September 2016 respectively. Portable appliance testing (PAT) was completed in accordance with good practice

Are services safe?

guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety. The last PAT certificate was in date and due for re-assessment in May 2016.

The practice had systems in place for the prescribing, recording, use and stock control of medicines used in clinical practice. Local anaesthetics were appropriately stored and batch numbers and expiry dates noted in stock records. There was a dedicated fridge for clinical materials and one for the storage of glucagon medicine used to treat low blood sugar level in a medical emergency. However, the practice was not monitoring and recording the fridge temperature used to store this medicine to ensure that it did not fall outside the recommended temperature range. The practice did not offer sedation but would prescribe diazepam to nervous patients if appropriate. All prescriptions were hand written and blank pads were securely stored.

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser (RPA) and a Radiation Protection Supervisor (RPS) in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The practice kept a well maintained radiation protection file in line with these regulations. This file included critical examination and acceptance certificates, initial risk assessments, local rules and appropriate notification to the Health and Safety Executive (HSE). Records demonstrated that x-ray equipment had been regularly serviced with the last one completed in September 2015. All routine maintenance schedules were logged. Both dentists were up to date with the General Dental Council (GDC) IRMER training requirements. The practice followed IRMER regulations as all dental x-rays taken were justified, reported and graded.

Patients were required to complete medical history forms and the dentist considered each patient's individual circumstance to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Dental care records showed that information related to X-rays was well documented and included grading of the x-ray, views taken, justification for taking the X-ray and clinical findings.

Radiograph audits had been undertaken by the practice in November 2014 which we saw were comprehensive and included actions taken from findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised guidelines and standards from the National Institute for Health and Care Excellence (NICE), General Dental Council (GDC), Faculty of General Dental Practice (FGDP) and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). These guidelines were present and readily available to staff. It was noted that guidelines were followed even where not necessarily applicable to private practice.

The practice maintained paper records of the dental care provided to patients. During the course of our inspection we discussed patient care with the dentists and checked dental care records for each dentist to confirm the findings. Each record documented in detail the clinical assessments undertaken and course of dental treatment provided. The records showed that clinical assessments included examination of the condition of patient's teeth and gum health and oral soft tissue assessment. We saw that Basic Periodontal Examinations (BPE) were recorded and that appropriate action was taken in more advanced cases. BPE is a simple screening tool used by dentists to indicate the level of treatment need in relation to a patients gums.

Medical history checks were updated for each patient every time they attended for treatment and entered in to their dental care record. This included an update on their health conditions, current medicines taken and known allergies. Justification for the taking of an x-ray was recorded and these were reviewed in the practice's programme of audits as per Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The records confirmed that a dental diagnosis was discussed with the patient and treatment options explained. Patients were provided with a copy of their treatment plan, including costs.

Care Quality Commission Comment (CQC) comment cards completed by patients reflected that patients were very satisfied with the care and treatment received and with their treatment outcomes.

It was observed that some clinical notes could be clearer in detail such as to include patients' smoking and alcohol habits, and risk assessments for caries.

Health promotion & prevention

The practice focused on preventative care and supported patients to ensure better oral health in line with the Public Health Document: 'Delivering better oral health: an evidence based toolkit for prevention'. Staff said they actively used this document when delivering health promotion information and guidance. 'Delivering better oral health' is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Patients were required to complete a medical questionnaire which included questions about smoking and alcohol consumption to support the dental team provide advice according to patients' individual needs. The waiting room and reception area displayed a range of literature promoting good oral health. This included information about effective dental hygiene and tips on how to reduce the risks of poor dental health. There was a selection of dental products on sale in the reception area to assist patients with their oral health.

Two part time dental hygienists worked at the practice and they and the dentists provided patients with advice to improve and maintain good oral health. One of the dental hygienists was in attendance at the practice on alternative Saturdays to support patients unable to attend dental hygiene appointments during the week. One of the dentists had in the past attended an educational school visit at a local primary school to talk about good oral health and how to achieve it.

Staffing

There were arrangements in place to support staff in their professional development and training. This included annual appraisals and training in mandatory topics such as basic life support, infection control, safeguarding children and radiography. An induction programme was in place for all new staff tailored to individual job roles. Dentists were up to date with their continuing professional development (CPD). (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of CPD to maintain their registration.) Records showed professional registration was up to date and dentists were covered by personal indemnity insurance. However, we observed that these records were not held for the visiting oral surgeon.

Are services effective?

(for example, treatment is effective)

There were processes in place to cover for staff absence including use of an agency dental nurse and hygienist from the sister practice. We were told that dental appointments would only be cancelled in the absence of one of the dentists, when the other was unable to provide cover.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice, for example orthodontic treatment and complex procedures. There was a comprehensive protocol for the referral of urgent cases where oral cancer may be suspected. This included follow up contact to the organisation where urgent referrals were sent. Referral letters contained detailed information regarding the patient's medical and dental history. In-house referrals were made to dental hygiene therapists and to a visiting oral surgeon for minor oral surgery.

Consent to care and treatment

The practice ensured patients were given appropriate information about their proposed dental treatment to enable them to give valid and informed consent. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Detailed information was also given to patients to review at home. Dental care records we reviewed included comprehensive consent documents which were appropriate to different types of dental treatments carried out.

We noted staff had not received formal training in the requirements of the Mental Capacity Act (MCA) 2005, however staff we spoke with understood the general principles of the Act. The Mental Capacity Act (MCA) 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff were aware of Gillick competency but they were not fully familiar of its implications. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from 28 patients about the service provided by the practice. All of the feedback described a very positive view of the service the practice provided. Patients said they felt the practice offered an excellent service and that the whole dental team were professional, caring, respectful and friendly. They said that they were treated with dignity and respect and that they felt listened to and supported by staff. Several references were made to the reassuring way the dental staff put people at ease.

A data protection and confidentiality policy was in place of which staff were aware. This covered disclosure of patient information and the secure handling of patient information. The practice held current registration with the Information Commissioner's Office (ICO). The Data Protection Act requires every data controller (for example organisation or sole trader) who is processing personal information to register with the ICO unless they are exempt.

The reception desk was separate from the patient waiting room which enabled reception staff to discuss private matters with patients. The treatment rooms were situated away from the waiting area so conversations could not be overheard.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices about their dental care and treatment. A number of information resources were exhibited to assist patients in decisions about their care and treatment. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the information given by staff. They told us that treatment options were explained clearly and in detail. This aligned with the views gathered by the practice through patient satisfaction surveys. We reviewed a sample of patient dental care records and saw examples of notated discussions with patients around treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Patients were emailed, called or a text message was sent to remind them of their appointments. Patient feedback comments confirmed that sufficient time was allocated for dental appointments and that appointments were available outside of normal working hours.

Information about the range of services offered to patients and private fee paying costs were prominently displayed in the reception area and on the practice website.

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. The treatment rooms, waiting room and patient toilet were all located on the ground floor and were accessible to patients who had restricted mobility. Translation services were available for patients where language maybe a barrier. The practice conducted an annual disability access audit review with the last completed in April 2015.

Access to the service

The practice was open from 9:00 am to 6.00 Monday, Tuesday, Wednesday and Friday from 9.00 am to 7.00 pm on Thursday and from 9.00 am to 2.00 pm on Saturday. The practice was closed for lunch between 1.00 pm and 2.00 pm Monday to Friday. Where treatment was urgent patients would be seen the same day where possible. When the practice was closed patients were directed by telephone recorded message to South West London dental triage line.

Concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures provided staff with guidance on how to support patients who wanted to make a complaint. This included details of organisations which patients could pursue matters further if they were not satisfied with the practice's handling of their complaint. Staff we spoke with were aware of the procedure to follow if they received a complaint. All complaints received were documented in a complaints record and actions taken recorded. There had been no complaints recorded in the last year.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks, for example fire safety and infection control.

There was a full range of policies and procedures in use at the practice which were accessible to staff in paper files. These included guidance about confidentiality, record keeping, incident reporting and data protection. There was a process in place to ensure that all policies and procedures were regularly reviewed and kept up to date as protocols or guidance changed. There were weekly informal practice meetings as well as monthly formal staff meetings with detailed minutes and action points from them recorded.

Leadership, openness and transparency

The practice had a statement of purpose which outlined their aims and objectives and gave details of the standards of care the practice was committed to. The culture of the practice encouraged candour and honesty to promote the delivery of high quality care. Staff told us that there was an open culture within the practice and that the management team were approachable to discuss any issues or concerns. They said that they felt comfortable about raising concerns and that they were listened to when they did. The practice displayed a General Dental Council (GDC) Standards poster in the patient waiting area, which set out the nine principles that registered dental professionals must adhere to at all times.

Learning and improvement

Staff told us the practice supported them to ensure that essential training was completed each year- this included basic life support and infection control. There was a comprehensive and effective approach for identifying where quality and or safety may be comprised and steps taken in response to any issues identified. The practice regularly audited areas of their practice as part of a continuous system of learning and improvement. These included radiography audits**,** infection control, patient records and prescriptions. Information from the findings of audits were used as learning tools to ensure improvements were made where needed.

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

The practice gathered feedback from patients through the use of patient satisfaction surveys, comment cards and complaints. We reviewed the latest patient satisfaction report for 2014 which demonstrated very positive feedback overall with responses either scored at above average or excellent. The highest scores were recorded in the fields for customer care, dentists and clinical arrangements. Lower scores were recorded for clinic opening times. The practice was reviewing the current arrangements in response.

The practice held regular staff meetings and annual staff appraisals had been undertaken. Staff told us that information was shared and that their views and comments were sought informally and their ideas listened to. They described that they felt valued and supported and were proud to work at the practice.