

Dentaz Ltd

The Dental Office

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 1st March 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

The Dental Office is located in the centre of Taunton and provides private treatment to patients of all ages. The practice consists of three treatment rooms, toilet facilities for patients and staff, a reception/waiting area and a staff room.

The practice offers treatment to both adults and children. However, no child patients had been seen since the practice opened. The practice offers routine examinations and treatment and cosmetic treatments. There is one dentist, a hygienist, a nurse and a practice manager.

The practice's opening hours are

9.30 to 17.30 on Monday

9.30 to 17.30 on Tuesday

9.30 to 17.30 on Wednesday

9.30 to 17.30 on Thursday

9.30 to 17.30 on Friday

10.00 to 14.00 on Saturday

We carried out an announced, comprehensive inspection on 1st March 2016. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor. The practice opened in November 2015 and was taking on new patients. At the time of our visit they had treated forty eight patients. There were no patients present during our visit.

Summary of findings

For this inspection five people provided feedback to us about the service through comment cards. Patients were positive about the care they received from the practice. They were complimentary about the service offered which they said was good and one said that it was fantastic. They told us that staff were caring and friendly. Patients told us that the practice was clean and hygienic. We received no negative comments.

We received some concerns posted on our website and we considered this information as part of the inspection.

Our key findings were:

- Safe systems and processes were in place, including a lead for safeguarding and infection control.
 - Staff recruitment policies were appropriate and most of the relevant checks were completed. Staff received relevant training.
 - The practice had ensured that risk assessments were in place and that they were regularly reviewed.
 - The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout.
 - The process for decontamination of instruments followed relevant guidance.
 - The practice maintained appropriate dental care records.
 - Patients were provided with health promotion advice to promote good oral care.
 - Written consent was obtained for dental treatment.
 - The dentist was aware of what process to follow when a person lacked capacity to give consent to treatment.
 - All feedback that we received from patients was positive; they reported that it was a caring and effective service.
 - There were governance systems in place at the practice such as systems for auditing infection control.
- There were areas where the provider could make improvements and should:
- Review the procedure for training staff about resuscitation and basic life support with a view to staff having the training together to help them to respond to an emergency as a team.
 - Review the process for recruitment to include two written references in line with current guidance about better recruitment.
 - Review the fire risk assessment to reflect the risk management measures in place such as fire safety checks, fire equipment checks and fire evacuations.
 - Review the process for cleaning and sterilising instruments to make sure that staff follow relevant guidance about testing the temperature of the water before washing instruments.
 - Review the positioning of paper towels in the surgeries to reduce the risk of contamination.
 - Review the policy about hand hygiene to make sure practice in relation to waste bins is in line with the policy.
 - Review the storage of clinical waste to make sure it is stored securely.
 - Review the process for transporting of clinical waste between practices and assess the risks and identify measures to control any risks.
 - Review the training for staff to include training about equality and diversity.
 - Review the arrangements for recording continual professional development (CPD) so that a record of all staff training is kept in the practice.
 - Review the arrangements for appraisal of staff to include a form of appraisal for the dentist.
 - Review the arrangements for accessibility to the practice and consider the use of translation services and a loop system.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. There was a business continuity plan. Hazardous substances were managed safely although some attention was needed to the storage of clinical waste.

Most of the appropriate checks were being made to make sure staff were suitable to work with vulnerable people. However, references were not always obtained. The necessary medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

The surgeries were fresh and clean. We found that guidance about decontamination of instruments was on the whole being followed to reduce the risk of the spread of infection.

Are services effective?

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

The dentists took X-rays at appropriate intervals. The practice was checking the condition of the gums for every patient and they were checking for oral cancers. Patients completed medical history questionnaires. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentist discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentist. Staff received appropriate professional development and most of the expected training except about equality and diversity.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for written consent to treatment. The dentist showed understanding about the Mental Capacity Act 2005 (MCA) and what they would do if an adult lacked the capacity to make particular decisions for themselves.

Are services caring?

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

Patients' privacy was respected and treatment room doors were closed during consultations. The practice used a paper record system and records were locked away so that they could not be seen by patients. There were also patient records held on the computer, which were password protected and backed up regularly.

Patients were positive about the care they received from the practice. They reported that staff were caring and friendly. Two patients commented that they were listened to and one said that they received 'absolutely fantastic care.' People were given treatment plans by the dentist, which they had signed to show their consent and agreement to them.

Summary of findings

Are services responsive to people's needs?

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

The practice had a system to schedule enough time to assess and meet patients' needs. The practice was taking on patients so people could get an appointment easily. Emergencies were usually fitted in on the day the patient contacted the practice. The practice was seeking feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation.

There was an equality and diversity policy but staff had not received training about equality and diversity. There was level access for wheelchair users to the downstairs surgery. However there were no other arrangements to make the service accessible to a range of people. There was no information about translation services for people whose first language was not English and there was no hearing loop system for patients who had a hearing impairment.

Are services well-led?

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

The practice had started systems for clinical governance such as audits of infection control. They planned to introduce audits of radiographs and record keeping when there were sufficient numbers to audit. There were checks of equipment. The autoclave was serviced and the compressor and radiography machines were new and arrangements were being made to service them. There were daily checks of the autoclave and ultrasonic bath.

The practice had a range of policies which were made available to staff. The practice manager held team meetings and staff discussed developments in the practice such as the new policies and procedures. Staff were responsible for their own continuing professional development and kept this up to date.

The practice manager was the lead for infection control, safeguarding and dealing with medical emergencies. The dentist was the lead for radiography. There was a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

The practice sought feedback from patients through patient satisfaction feedback forms. As the practice was new there had not been any completed so far. The practice manager planned to make changes in the practice in response to this feedback.

The Dental Office

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 1st March 2016. The inspection took place over one day.

The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

We reviewed information received from the provider before the inspection. We also informed the local Healthwatch and NHS England of our visit. We did not receive any information from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with the practice manager and the dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The practice manager talked us through the process for decontamination of dental instruments. There were no patients present on the day of our visit.

Five people provided feedback about the service. Patients, who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

We received feedback on our website about the practice and took this into consideration as part of the 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.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were safety procedures including information about how to report to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was an accident book and a procedure for reporting accidents. Staff would report any accidents or incidents to the manager. There had not been any accidents or incidents in the practice since it opened in November 2015.

Reliable safety systems and processes (including safeguarding)

There was a procedure about what to do if a member of staff had a sharps injury. A sharps injury is when a person is injured by a needle or other sharp dental instrument. We saw a record in the dentist's recruitment file to show that the procedure had been followed in their other practice and what action was taken. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. This included a flow chart with the contact details for the local authority social services. The practice manager was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed training about safeguarding adults and children. Staff would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. There was also a Being Open policy about the practice being open if things went wrong. This included the provisions of Regulation 20 about the duty of candour, for example, notifying a patient if they had been harmed as a result of their treatment, offering an apology and providing support to the person. There was a complaints procedure so patients could complain if they had a concern about their treatment.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency

resuscitation and basic life support and we saw certificates for this training. The staff had completed this training individually. Team training to help them to work together in a medical emergency had not been provided. The manager and the dentist were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). There were defibrillator pads for both adults and children. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness. We reviewed the contents of the emergency medicines kit. We saw records of weekly and monthly audits of the medicines and equipment and all the emergency medicines were in date. The glucagon injections were being kept in the fridge.

Recruitment

The practice staffing consisted of one dentist, one hygienist, one trainee dental nurse, and a practice manager. We looked at the records of recruitment checks for two staff. Each member of staff had completed a curriculum vitae. They each had a disclosure and barring service (DBS) check and had a copy of their passport and photo driving license as proof of identity and information about their right to work in the UK. One member of staff had only one written reference, from their previous employer and the other member of staff had a verbal reference. These provided information about whether the new staff were of good character and about the conduct of prospective new staff in their previous employment. There were records of the immunisation status of the nurse, hygienist and dentist. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for all the qualified staff.

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy and a risk management policy. The practice had a fire risk assessment. This identified the risks relating to fire but did not include risk management measures such as fire safety checks, fire equipment checks and fire evacuations. However, fire safety measures were in place. There were

Are services safe?

smoke alarms and the practice manager tested these weekly. There were fire extinguishers and there were arrangements to have these serviced annually. The practice manager said that they aimed to have an evacuation every six months. There was a health and safety risk assessment for the general risks in the practice. This included the action to be taken to manage risk and the practice manager planned to review it annually.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There were COSHH risk assessments and there were also safety data sheets for hazardous substances and cleaning products.

The practice followed national guidelines on patient safety. For example, the practice used a rubber dam for root canal treatments. 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.

The practice had a business impact analysis and a disaster plan with emergency procedures to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were systems to reduce the risk and spread of infection. The practice manager was infection control lead for the practice. There was a comprehensive infection control policy displayed in the decontamination room. There was also a hand hygiene policy. This stated that the bins for clinical waste were foot operated. However, this did not reflect practice. We noted that the bins in the treatment rooms were behind cupboard doors that needed to be opened manually. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. We received a concern posted on our website that there was no water to wash hands in the staff toilet. We found that there were hand washing facilities in the decontamination room, the treatment rooms and the downstairs toilets. The practice manager said that staff used the downstairs toilet and they had ordered a new tap for the staff toilet so that the hand wash facilities could be repaired. We noted that paper towels

were placed on the work-surface close to the hand wash sink in one of the surgeries. This poses a risk of contamination. The practice manager told us that the dentist, nurse and hygienist wore uniforms in the clinical areas and they were responsible for laundering these. We found that cleaning schedules were completed and the practice looked clean throughout. The nurse cleaned the surgeries. Five people who completed comment cards said that the environment was always clean and hygienic. Ten people who completed comment cards said that the environment was safe and hygienic.

We examined the facilities for cleaning and decontaminating dental instruments in the decontamination room. The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' when setting up their decontamination room. In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spread of infection was minimised.

There was a clear flow from 'dirty' to 'clean' and the areas were colour coded to ensure separation. There were two sinks, one for washing and one for rinsing and an ultrasonic bath. The practice manager described the process for decontamination of instruments. They said that the nurse would put on personal protective equipment (PPE) including domestic style rubber gloves. The nurse washed the instruments in the washing bowl but there was no thermometer to test the temperature of the water to make sure it was in line with the guidance. The practice manager said the nurse would monitor the temperature with their hand. The practice manager described how the nurse would scrub the instruments underwater then place them in the ultrasonic bath. After the ultrasonic bath cycle was complete the nurse would inspect the instruments for debris under an illuminated magnifying glass, place them on trays and put them into the autoclave to sterilise. After the sterilisation cycle was complete they took the instruments out of the steriliser to the clean area of the room, put them into date stamped bags and put them into a clean container to take back to the surgery. The practice manager also showed us how the nurse cleaned down the surgeries between patients. They used a paper towel and disinfectant spray to sanitise the surfaces.

Are services safe?

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. We saw a certificate to show that it was serviced annually. There were records to show that there were regular checks of the ultrasonic bath.

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out a cross infection audit. The practice had an on-going contract with a clinical waste contractor in another practice which they ran. Waste was being appropriately segregated however the clinical waste was being stored on a balcony outside so there was a risk of attracting vermin. The practice manager said that they had only small amounts of clinical waste. They took the clinical waste and sharps in containers to the other practice in their car to be collected by the contractor. We saw records to show they had been collected by the contractor.

There was a Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings.) We saw records of monthly checks of the temperatures at the cold and hot water outlets. The practice manager described how the nurse flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella.

Equipment and medicines

We saw a certificate which showed that the air compressor, fire equipment and X-ray equipment used at the practice were new and safe to use. The practice manager planned to service equipment annually. The autoclave was not new and we saw a certificate to show that it was serviced in

September 2015. The electrical wiring had been replaced as part of the surgery refurbishment. We saw an up-to-date portable appliance testing (PAT) policy which stated that portable appliances should be visually inspected and it identified which electrical items needed to be PAT tested. We received a concern posted on our website that none of the electrical appliances were PAT tested. However, all the portable electrical items were new and did not require testing. We received a further concern posted on our website that there were no disposable three in one tips. These are the disposable, single use, tips for the 3-in-1 syringe on the Dental Unit. We found that there were no single use tips but there were two sterilisable ones and the practice manager said that they would order some single use tips.

Medicines were stored securely in a cupboard and a designated fridge. The defibrillator and oxygen cylinder were stored in a cupboard on the top floor.

Radiography (X-rays)

There was an X-ray unit in each of the two dental surgeries. There were suitable arrangements in place to ensure the safety of the equipment. We saw logs to show that they were maintained. The name of an external radiation protection adviser (RPA) was made available and the principal dentist was the radiation protection supervisor (RPS). X-rays were graded as they were taken. The practice was new and few x-rays had been taken so there was no audit of radiographs. The practice manager said that they planned to undertake audits. We saw evidence that the dentist had received training about radiography and that this was due for updating later this year.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed eight adult dental care records; there were no children's records. The dentist took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. The records showed that an assessment of periodontal tissues was undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.) Patients' BPE scores were recorded.

We found evidence that the practice conducted an audit of infection control and they planned to conduct audits of radiographs and record keeping. Patients completed a medical history on their first visit and these were recorded in their notes. So far none of the patients had come for a second time so the histories had not yet been updated.

We saw evidence that the practice kept up to date with current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to referring patients for removal of wisdom teeth and prescribing antibiotics. The dentist decided on the appropriate intervals for recalling patients based on risk. We found evidence that the practice had protocols and procedures in place for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.

Health promotion & prevention

The dentist said that they discussed health promotion with individual patients according to their needs. This included discussions around smoking and sensible alcohol use. We saw records of examinations of soft tissue to check for the early signs of oral cancer.

The practice promoted the maintenance of good oral health through information about effective tooth brushing.

We observed that there was some information about tooth brushing displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

There was a practice manager, a dentist, a trainee nurse and a dental hygienist. There had been some staffing issues but the practice manager was managing these. The practice manager was covering the cleaning until the practice expanded. The practice manager was also a dental nurse so they could cover if the nurse was absent.

The practice manager told us that all staff received professional development and training. Training for staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, health and safety and the Mental Capacity Act 2005 (MCA.) We noted that there was no training planned about equality and diversity. The dentist, hygienist and the nurses were responsible for their own continuing professional development (CPD.) We saw a large range of training certificates for the dentist. The nurse had a personal development plan to support them with their learning. However, there was no record in the practice of the CPD hours the hygienist had completed. An annual appraisal had been completed by the practice manager for the nurse. We found no evidence of an appraisal or peer review for the dentist.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentist had referral letter templates to make a referral to another provider, for example, for oral surgery, orthodontics or endodontics. Where there was a concern about oral cancer a referral would be made to the local hospital. We saw that there had been one referral made so far for periodontal treatment.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. The dentist told us that they discussed treatment options, including risks and benefits, as well as costs, with each patient. We saw records of discussions in the patient records. We also saw records of people's consent to treatment.

When we spoke with the dentist and the practice manager we found that they had an understanding about the Mental

Are services effective?

(for example, treatment is effective)

Capacity Act 2005 (MCA.) The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentist had not come across a situation where a person lacked

capacity to consent. They had received training about the MCA. The practice had a template to use to help them to assess a patient's capacity to consent if there was a concern.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice used a paper record system. We noted that records were locked away so that they could not be seen by patients. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. The waiting room was away from the consulting rooms so that conversations could not be heard from the other side of the door. There was a separate consulting room where patients could discuss issues with the dentist or hygienist in private. Patients who completed comment cards said that they were treated with respect.

Patients who completed comment cards, were positive about the care they received from the practice. Patients

reported that staff were caring and friendly. They said that they provided a very good service. One patient commented that they received 'absolutely fantastic care.' Two people commented that they were listened to.

Involvement in decisions about care and treatment

The practice provided treatment plans for private patients which gave options for treatment and indicative costs. Written consent was obtained for the dentist's treatment plans showing that people were involved in decisions about their care. Two patients said in their comment cards that the dentist explained treatment to them very clearly so that they could make decisions. The patient records showed that any issues or options for treatment were discussed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. The practice gave each new patient a 60 minute appointment to allow time to conduct a full assessment of their needs. Patients commented that the staff provided a good service. So far there had been no emergencies but the practice manager said that the dentist would fit in anyone who needed to be seen in an emergency. The practice was seeking feedback from patients on the care being delivered. There were feedback cards in reception but there had been few patients so far and no-one had completed one.

Tackling inequity and promoting equality

There was an equality and diversity policy but there was no training about equality and diversity. There was a ground floor surgery where the dentist or hygienist could see

patients who could not manage the stairs. We saw no information about translation services for people for whom English was a second language. The practice manager said that they had so far not needed translation services. There was no loop system for people who had a hearing impairment.

Access to the service

The opening hours were displayed in reception. The practice was taking on patients and people had no difficulty getting appointments. Emergencies would be fitted in on the day the patient contacted the practice.

Concerns & complaints

There was a procedure about how to make a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was displayed in the reception area. There had been no formal complaints. Any complaints would be logged and responded to.

Are services well-led?

Our findings

Governance arrangements

The practice had systems for clinical governance. There were audits of emergency medicines and infection control. The practice manager planned to introduce auditing of record keeping and radiographs when there were sufficient to audit.

There were checks of equipment. We saw evidence that the autoclave was serviced. The compressor and radiography machines were new and the practice manager was arranging for these to be serviced at the appropriate times. The practice manager told us that they conducted daily checks of the autoclave and ultrasonic bath and we saw records of these tests in a log book.

We saw that there was a range of policies which were made available to staff.

Leadership, openness and transparency

The practice manager was the lead for the practice and they were also the lead for infection control, safeguarding and medical emergencies. The dentist was the lead for

radiography. We saw information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The practice manager told us that there were regular team meetings. We saw the minutes of meetings, which showed that staff discussed developments in the practice such as the new policies and procedures. The nurse and hygienist were responsible for their own continuing professional development and kept this up to date. There was also training within the practice and we saw records to show that relevant training was taking place, for example for safeguarding and health and safety.

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

There were patient satisfaction feedback forms in reception and the practice manager planned to analyse these regularly and make changes in response to feedback. So far no patients had completed feedback forms.