Mr. David Medcalf

Lovat House Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28th 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

Lovat House Dental Practice is located in the centre of Cheltenham and provides private treatment to adults and NHS treatment to children. The practice consists of four treatment rooms, toilet facilities for patients and staff, a reception area and waiting area.

The practice offers routine examinations and treatment. There is one dentist, who is also the registered provider, two dental hygienists, one dental nurse and two receptionists. This provider shares the facilities in the practice with two other dentists who are also registered separately as providers.

The practice's opening hours are

Monday to Thursday 9am to 1pm and 2pm to 5pm

Alternate Fridays 9am to 12noon

Out of hours the three dentists took turns to be on-call and patients were directed to phone the dentist on-call.

We carried out an announced, comprehensive inspection on 28th March 2017. The inspection was led by a CQC inspector who was accompanied by a specialist dental advisor.

For this inspection 6 people provided feedback to us about the service. Patients were positive about the care they received from the practice. They were

Summary of findings

complimentary about the service offered, which they said was excellent. They told us that staff were kind, helpful, caring and respectful and the practice was clean and hygienic.

Our key findings were:

• Safe systems and processes were in place, including a lead for safeguarding.

• Staff recruitment needed to be improved because relevant checks had not been conducted for the most recent person employed. Staff received relevant training.

• The practice had ensured that some risk assessments were in place. We found that there was no Legionella risk assessment had the fire risk assessment had not been carried out by an appropriately qualified person.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout although parts of the surgery were cluttered.

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained appropriate dental care records and patients' health details were updated. We found that some clinical details were not always recorded.

• Patients were provided with health promotion advice to promote good oral care.

• Consent was obtained for dental treatment.

• The dentist was aware of the 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, respectful and helpful service.

• There were arrangements for governance at the practice such as systems for auditing infection control, radiographs and patient records.

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

- Review the procedure for dealing with accidents so that it includes a record of the investigation of the accident and of any follow up action needed.
- Review the recruitment procedures to ensure that Disclosure and Barring Service (DBS) and references are obtained before new staff start work in the practice in line with current guidance.
- Review the arrangements for support to staff to make sure all staff receive regular appraisals and personal development plans.
- Review the arrangements for fire safety including the fire risk assessment.
- Review the arrangements for prevention of Legionella.
- Review the layout of the surfaces and cupboards in the surgery and the room with the X-ray developer to ensure they are free from clutter and are easy to clean.
- Review the storage of paper records to make sure that patient records are stored securely to ensure confidentiality.
- Review the arrangements for communication to include a hearing loop for patients with a hearing impairment and access to a translation service for people whose first language is not English.
- Review the arrangements for recording patient information to make sure that a Basic Periodontal Examination (BPE) is conducted at each check-up appointment and the scores are always recorded.
- Review the arrangements for obtaining patient feedback to make sure questionnaires are reviewed at regular intervals and improvements are identified as a result of feedback.
- Review the arrangements for auditing to make sure that the infection control audits are more in depth and include action plans and learning outcomes.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

There were systems for reporting accidents and incidents and for learning from incidents but these could be improved. 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. Attention was needed to the fire safety checks and the fire and Legionella risk assessments. There was a business continuity plan. Hazardous substances were managed safely.

Appropriate checks were not being made to make sure staff were suitable to work with people. Emergency medicines were in place. Equipment was regularly serviced and X-rays were dealt with safely.

The surgeries looked clean although one was cluttered and guidance about decontamination of instruments was being followed to reduce the risk of the spread of infection.

Are services effective?

No action

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

The dentists took X-rays at appropriate intervals. The dentist was not routinely checking the condition of the gums of patients and there were no records of these checks in the records, which we read. They were checking for oral cancers. Patients completed medical history questionnaires and these were updated at each visit. 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 dentists. Staff received appropriate professional development and most of the expected training.

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 consent to treatment. The dentists discussed options for treatment with patients. The dentist showed understanding about the Mental Capacity Act 2005 (MCA) and knew what they would do if an adult lacked the capacity to make particular decisions for themself

Are services caring?

No action

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

Summary of findings

Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were kind, helpful, caring and respectful.

Are services responsive to people's needs?

No action

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

The practice had a system to schedule enough time to assess and meet patients' needs. Patients said that they could get an appointment easily. Emergencies were usually fitted in on the day the patient contacted the practice. The practice sought feedback from patients on the care being delivered. We found, they did not analyse this at regular intervals to identify improvements to the service. There was a procedure about how to make a complaint and the process for investigation.

There was an equality and diversity policy and staff had received training about equality and diversity. There was a toilet with disabled access. There was level access to the surgeries so that people with who used wheelchairs could access the service. We found there was no hearing loop system for patients who had a hearing impairment and there was no information about translation services for people whose first language was not English.

Are services well-led?

No action

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

The practice had set up systems for clinical governance such as audits of the infection control, record keeping and radiographs. Improvements needed to be made to the audits of record keeping and infection control to make them more effective. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had a range of policies which were made available to staff.

The dentist was the lead for the practice. There was a whistleblowing policy but there was no 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 held team meetings every three months. Staff were responsible for their own continuing professional development and kept this up to date.

The practice was seeking feedback from patients through patient satisfaction questionnaires and the NHS friends and family test. They needed to analyse the questionnaires at regular intervals and identify improvements in response to the feedback.

Lovat House Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection 28th March 2017. The inspection was led by a CQC inspector who was accompanied by a dental specialist advisor.

We reviewed information received from the provider before the inspection. During our inspection visit, we met with the two receptionists, a dental nurse, one hygienist and the dentist who was also the registered provider for the practice. A registered provider is a 'registered person' who has legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we looked at the NHS Choices website but there had been no reviews in the past year.

We also contacted NHS England and Healthwatch. We received no information from NHS England or Healthwatch about the practice.

We reviewed policy documents and dental care records. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed a dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Fourteen 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 skillful, friendly and caring attitude of the dental staff.

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 a system for reporting and learning from incidents but this could be improved. There was an accident book and information about reporting to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) if applicable.

There was a written untoward incident procedure. Staff would report any incidents to the dentist. There had been one accident and no incidents in the last twelve months. The accident form contained no record of an investigation or of follow up action.. We noticed that the practice had guidance about effective staff meetings which suggested that learning from accidents, incidents and complaints should be regular agenda items. The meeting minutes we saw showed that this guidance was not being followed.

There was no specific information for staff about the duty of candour, which means being open and honest with people when they have been harmed as a result of their care. There was information in the incident policy stating that if a patient was harmed as a result of their treatment the practice would provide an explanation of the incident and any action which needed to be taken and an apology would be given where appropriate. We found this did not refer specifically to the duty of candour. There had been no such incidents.

Reliable safety systems and processes (including safeguarding)

There was a written procedure to follow if a member of staff had a sharps injury. A sharps injury is when a person is injured by a needle or other sharp object. There had been one accident recorded in the accident book. This had no record of an investigation or follow up action and was not linked with the sharps injury procedure. There were systems to reduce the risk of a sharps injury including sharps bins in each surgery and use of a safety system for re-sheathing needles. We saw evidence that staff were immunised against Hepatitis B to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services. There was a nominated lead for safeguarding vulnerable children and adults. We saw certificates to show that staff had received training 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 information for staff about safeguarding and whistleblowing in the individual staff files.

The dentist received safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA) and NHS England. The nurse told us that the dentist would print off information about any relevant alerts and share it with staff.

Staffing and Recruitment

The practice staffing consisted of one dentist, two dental hygienists, two dental nurses and two receptionists. Most of the staff had worked in the practice around 20 years. We looked at the recruitment records of a member of staff who had been recruited to the practice more recently. We found that no recruitment checks had been conducted when they were employed. The dentist said that one of the dentists who shared the practice facilities had known the person in a previous practice. We were told that one of the other member of staff had not had a Disclosure and Barring Service (DBS) check either. There was a record of the immunisation status of the clinical staff. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for the qualified staff. There were certificates of qualifications.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates for this training. The staff we spoke with 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).

Are services safe?

The medical oxygen cylinder and resuscitation mask were in date. The medical oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. 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.

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 risk assessment for the general risks in the practice. This included the action to be taken to manage risk. The practice had a fire risk assessment which had been undertaken in the practice rather than by an external qualified professional.

There was a fire log book to record weekly and monthly fire safety checks and when fire evacuations took place. The records showed that there had been an annual service of the fire extinguishers but there were no other records. Two receptionists told us that one of the dentists, who shared the practice facilities, tested the smoke alarms once a month but there were no records of these tests. They also said that fire evacuation practices did not take place but they knew what to do and they knew where the assembly point was.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There was an annual COSHH checklist for all the products used within the practice.

There were some loose tiles in the hallway leading to the waiting room which could be a trip hazard.

The practice followed national guidelines on patient safety. For example, the dentist referred patients to a root canal specialist when indicated. This meant that he did not routinely need to use a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society.

The practice had a business continuity plan 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. There was a health and safety policy which identified one of the dentists who shared the practice facilities as infection control lead for the practice. There was an infection control policy and an annual self-assessment audit of infection control measures in the practice. These audits were not conducted at the recommended frequency of every six months.

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. There were hand washing facilities in the treatment rooms and the toilet. The clinical staff wore uniforms in the clinical areas and they were responsible for laundering these.

There was no Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). There were no monthly checks of the temperatures at the cold and hot water outlets. A test of the water supply took place in February 2017 and no Legionella was found. The dental nurse showed us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella. They said that the dental water lines were cleaned once a week.

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.' There was an ultrasonic bath and two sinks, one for washing and one for rinsing. The dental nurse showed us the process for decontamination of instruments which followed current guidance.

There autoclave and ultrasonic bath were checked daily and weekly for 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 certificates to show the autoclave and ultrasonic bath were serviced annually.

The practice was following relevant guidance about cleaning and infection control. Cleaning schedules were completed and the practice looked clean throughout. The practice used a cleaning company and they brought their own cleaning equipment. The dental nurse cleaned the surgery. We noted that the surgery surfaces and cupboards were cluttered which could make them difficult to clean. Patients confirmed that the environment was always clean and hygienic.

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out cross infection audits. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) for electrical items took place and the most recent test was in January 2017. There was a current fixed electrical wiring certificate.

Medicines were stored securely in a cupboard and a designated fridge. The temperature of the fridge was recorded. Prescription pads were kept securely. The defibrillator was kept in a central location There was a medical oxygen cylinder with an up to date certificate. Staff said that there were sufficient dental instruments.

Radiography (X-rays)

There was an X–ray unit in the surgery. There were suitable arrangements in place to ensure the safety of the equipment. We saw a log to show that the X-ray machines were maintained and the most recent examination in took place in March 2017 and they were awaiting a certificate. We saw a radiation protection file which contained the name of the Radiation Protection Advisor but there was no identified Radiation Protection Supervisor.

The file contained the necessary records relating to the X-ray equipment. There was a critical examination pack for each X-ray set along with maintenance logs and a copy of the local rules. The local rules describe the operating procedures for the area where X-rays are taken and the amount of radiation required to achieve a good image.

There was no evidence of a Health and Safety Executive (HSE) notification and the dentist said that they would make sure a notification was made. The dentist used a system of manual X-rays and the developing machine was in a room next to the decontamination room. This was room was cluttered. Developer and fixer were disposed of safely. We saw records of audits of the radiographs.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records with the dentist and found that 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 dentist told us that an assessment of periodontal tissues was not always 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.) BPE scores were not recorded in the dental care records we read. The dentist said that they referred patients on to the dental hygienist if they had gingival pockets.

We found evidence that record keeping was audited. We saw that information about medical history was entered in patients' dental records and the records showed that this was reviewed and updated at every visit. This information was kept up to date so that the dentists were informed of any changes in patients' physical health which might affect the type of care they received.

We saw evidence that the practice kept up to date with the 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. They conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. The dentist was not aware of the Department of Health Delivering Better Oral Health Toolkit when considering care and advice for patients. This was discussed with dentist who agreed to familiarise themself with this guidance.

Health promotion & prevention

The dentist discussed health promotion with individual patients as part of the routine examination process. 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 information about tooth brushing and health promotion 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.

Staff skills and experience

The dentist and dental nurse told us that all staff received professional development and training. Courses for all staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, equality and diversity and infection control. The dentist had recently had training about the Mental Capacity Act 2005 (MCA) and planned to share it with all the staff. The clinical staff were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the General Dental Council (GDC.) We saw evidence that the dental nurse and the dentist were keeping their CPD up to date.

We found that there was no system of appraisals or personal development plans for staff.

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 used a system of onward referral to other providers, for example, for oral surgery and orthodontics. Where there was a concern about oral cancer a referral was made to a local hospital. Referral information was sent to the specialist service about each patient, including their medical history and X-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. There was information about the practice consent policy in the waiting room. This stated that the dentist would always discuss options for treatment, including the risks and benefits, with patients. We saw records of written consent in the patient notes. We spoke with the dentist who told us that they discussed options for treatment with patients. When treatment was needed for children the dentist obtained consent from their parents, or if a child was older and able to decide they obtained consent from the young person. The dentist told us how they involved children in decision making about their treatment through explaining and showing them what was going to happen using pictures.

Are services effective?

(for example, treatment is effective)

We found that training for staff about the Mental Capacity Act 2005 (MCA) was planned. We spoke with the dentist who demonstrated knowledge about the MCA and capacity to consent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice had changed from paper records to an electronic system of patient records. Electronic records were password protected. The computer screens in reception could not be seen by patients. We found paper patient records in open boxes in the room next to the decontamination room. These should be locked away.

Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. If a patient wished to discuss something with the receptionist in private they were invited into a treatment room. We observed that staff in the practice were friendly, polite and respectful when speaking to patients.

Patients, who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were kind, helpful, caring and respectful. They said that they provided an excellent service.

Involvement in decisions about care and treatment

The practice provided treatment plans for patients including costs. There was an electronic tablet in reception where patients could read their treatment plan and provide consent. Patients said that the dentist explained treatment to them very clearly and listened to their views so that they could make decisions.

S**upport to patients**

The receptionists scheduled longer appointment when a patient was nervous. The dentists said that they put people at their ease by chatting and explaining their treatment in simple terms and by showing them what was going to happen. Patients who required urgent treatment were usually fitted in on the day they requested an appointment. An emergency appointment slot was kept every morning and afternoon for each dentist.

Patients told us that the dentists always listened to what they had to say. They said that they could always get emergency care when they needed it.

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 dentist said that they assessed the time it would take for treatment so that they could space out appointments. Emergencies were usually fitted in on the day the patient contacted the practice. The practice kept designated emergency appointments each day. Patients commented that the staff provided an excellent service. They told us that when they had had an emergency they were seen the day that they contacted the practice and it was easy to make an appointment. The receptionist told us that they allowed extra time when booking appointments for nervous patients. They said that there was an alert on the patient records when a patient was nervous.

The practice sought feedback from patients on the care being delivered through feedback questionnaires in the surgery. We found they did not have any specific timescales for analysing these and we saw no examples of improvements made as a result of comments from patients.

Tackling inequity and promoting equality

There was an equality and diversity policy and staff had received training.There was level access to the practice for wheel chair users and the treatment rooms were on the ground floor. There was also a disabled access toilet.

We found that there was no hearing loop system for deaf people. There was also no access to a translation service for people whose first language was not English.

Access to the service

The opening hours were displayed in reception and in the practice brochure. Patients told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day the patient contacted the practice. For out of hours care patients were advised to contact an on-call dentist.

Concerns & complaints

There was a procedure for making a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was displayed in reception and was given to patients on request. Information about concerns and complaints would be recorded and there was a complaints log. There had been no formal complaints in the last year. We saw letters and cards from patients giving compliments about the practice.

Are services well-led?

Our findings

Governance arrangements

The practice had set up systems for clinical governance. There were audits of infection control, radiographs and record keeping. These could be improved. For example,the audits of infection control were conducted annually when the guidance states that they should be conducted six monthly. They were in the form of a checklist and did not include analysis of the findings or action to reduce the risk of infection for example conducting a Legionella risk assessment and taking water temperatures.

There were checks of equipment. We saw evidence that the ultrasonic bath, autoclave and compressor and X-ray machines were serviced. The nurse told us that they conducted daily checks of the autoclave and ultrasonic bath and we saw records of these tests. We saw that there was a range of policies which were made available to staff. Appropriate records were kept but these could be improved, for example by recording BPE scores.

Leadership, openness and transparency

The dentist was the lead for the practice, medical emergencies and investigating accidents and one of the dentists who shared the practice facilities was the lead for safeguarding and monitoring of equipment. The other dentist who shared the practice facilities was the lead for health and safety, infection control, radiation safety, COSHH and safety training.

We saw that there was no specific information for staff about the duty of candour. There was information in the incident policy stating that if a patient was harmed as a result of their treatment the practice would provide an explanation of the incident and any action which needed to be taken and an apology would be given where appropriate. So far there had been no incidents where patients had suffered harm as a result of their treatment. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The dentist and nurse told us that there were team meetings every three months and we saw minutes of these meetings. The nurses told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw records to show that relevant training was taking place, for example for safeguarding and health and safety. There was no system of appraisals and personal development plans for staff.

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

The practice used the NHS friends and family test and patients said that they would recommend the practice. Patient satisfaction questionnaires were in reception but there was no regular system for analysing information from these and we saw no examples of improvements as a result of patient feedback.