Chelsea and Fulham Dentist Partnership

Chelsea and Fulham Dentist

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 July 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

Chelsea and Fulham Dentist is located in Fulham, West London. The practice provides private dental services and treats both adults and children. The practice offers a wide range of dental services including general, cosmetic, restorative and preventive dentistry. The practice also offered a dental implant and orthodontic service provided by visiting specialists.

The staff structure of the practice comprised two principal dentists, two trainee dental nurses, and two visiting specialists.

The practice is open Monday from 9.00am to 8.00pm and Tuesday to Friday from 9.00am to 6.00pm.

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

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

We received 21 CQC comment cards completed by patients. No patients attended the practice during our inspection visit as it was a non-clinical day. Patients who

Summary of findings

completed comment cards were very positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance, such as from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice (FGDP).
- Equipment, such as the air compressor, autoclave, oxygen cylinder, Automated External Defibrillator (AED) and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients including mandatory training and annual appraisal.
- Patients reported that they felt they were listened to and that they received good care from a helpful and respectful practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints, proactively sought feedback from patients and staff and acted on it to improve the service provided.
- There was a clear vision for the practice and staff were well supported by the management team.
- There were governance arrangements in place and the practice effectively used audits to monitor and improve the quality of care provided.

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

- Arrange training in safeguarding of vulnerable adults for staff who have not received this.
- Arrange for trainee dental nurses to receive child protection training to supplement training received in their dental nurse training course.
- Review its recruitment procedures to ensure, records are kept of both written and verbal references sought prior to appointment.
- Arrange for the employment contracts of the two visiting specialists to be placed on their staff files.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols related to the safe running of the service and these were communicated to staff who had ready access to them. There was a safeguarding lead and staff were made aware of their responsibilities in terms of identifying and reporting any potential abuse. Equipment was well maintained and checked for effectiveness. The practice had systems in place for waste disposal, the management of medical emergencies and dental radiography. Staff engaged in training to keep their skills up to date.

The practice had a recruitment policy in place, which included pre-employment checks. However, we noted that the practice had not kept copies of references for all members of staff and we were told some references were obtained verbally but not recorded. In addition there was no written contract on file for two visiting staff who occasionally carried out dental implant and orthodontic work.

Are services effective?

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

The practice demonstrated that they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice (FGDP). The practice monitored patients' oral health and gave appropriate health promotion advice. Patients confirmed that staff explained treatment options to ensure they could make informed decisions about any treatment. There were systems in place for recording written consent for treatments. The practice maintained comprehensive dental care records and details were updated appropriately. The practice referred patients to other health care professionals when necessary.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Feedback from patients showed that they were treated with dignity and respect. Patients were positive about the helpful and caring attitude amongst the staff. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients were satisfied with access to appointments, including emergency appointments, which were available on the same day. Members of staff spoke a range of languages which supported good communication between staff and patients. The practice was unable to provide full access to people with disabilities but an extension to the premises was due to be carried out which would allow this. Patients were invited to provide feedback via satisfaction surveys and via the website. There was a clear complaints procedure and information about how to make a complaint was available in the waiting area.

Are services well-led?

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

Summary of findings

There were good clinical governance and risk management systems in place. There were regular staff meetings and systems for obtaining patient feedback. We saw that feedback from staff or patients had been carefully considered and appropriately responded to. The practice had a clear mission statement in place. The mission statement was shared with all members of staff. Staff were encouraged to raise any issues or concerns with the registered manager. They indicated through appraisal that they were supported in their roles.

Chelsea and Fulham Dentist

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 2 July 2015. The inspection took place over one day. The inspection was led by a CQC inspector who was accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection.

During our inspection visit, we reviewed policy documents. We spoke with the management team including the two principal dentists, both of whom were partners in the practice and one of whom was the registered manager. Other staff were not present as it was a non-clinical day at the practice. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The registered manager demonstrated the decontamination procedures of dental instruments and we examined the decontamination area and related infection control procedures.

We reviewed 21 Care Quality Commission (CQC) comment cards completed by patients and spoke with two patients in the waiting area. 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.

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 had been one incident reported in the past year. This related to a scissors injury and the practice had recorded this in its accident book. There was a significant event policy in place which described the actions that staff needed to take in the event that something went wrong or there was a 'near miss'. The principal dentists confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had a child protection and safeguarding adults policy in place. This provided staff with information about identifying, reporting and dealing with suspected abuse. The policy was accessible to staff and included the contact details for the child protection and safeguarding adults teams which were on display in reception. The two principal dentists we spoke with knew how to report concerns and who they would contact if they suspected abuse.

The registered manager, who was also one of the principal dentists, was the safeguarding lead for the practice. There had been no safeguarding issues reported by the practice to the local safeguarding team. We saw records that confirmed the two principal dentists had received safeguarding training, one to Level 3 and the other Level 2. The orthodontist and implantologist who undertook occasional work at the practice had both received child protection training but details were not available at what level. In addition there were no details of any safeguarding adults training. The practice had recently appointed two trainee dental nurses and at the time of the inspection they had not undertaken safeguarding training but we were told this would be arranged. They would also be covering safeguarding of children and vulnerable adults in their dental nurse training.

The practice had a whistleblowing policy to enable staff raise any concerns of malpractice by other staff members. No staff were present on the day of the inspection. However, the principal dentists told us the policy had been discussed with staff at a practice meeting and we saw evidence of this. They felt as a result staff would be confident about raising concerns under the policy.

The practice had safety systems in place to help ensure the safety of staff and patients. These included protocols to follow in relation to sharps injuries (for example injuries sustained from handling needles or sharp instruments). There were adequate supplies of personal protective equipment such as face visors and heavy duty rubber gloves for use when manually cleaning instruments.

The dentists used rubber dam when carrying out root canal treatment in accordance with guidance 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.) There was a kit in the surgery with non-latex dam as one of the dentists was allergic to latex.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies in accordance with the Resuscitation Council (UK) guidelines. An emergency resuscitation kit was available. The kit did not contain a portable suction kit and child ambu –bag. However, the practice obtained these during the inspection to ensure the completeness of the kit. The practice had an Automated External Defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electric shock to attempt to restore a normal heart rhythm).

Oxygen and medicines for use in an emergency were available and complied with the latest recommendations from the Resuscitation council (UK). Records showed weekly checks were carried out to ensure the emergency equipment was fit for purpose and the emergency medicines were in date.

Staff had received training in basic life support and medical emergencies in the previous year and it was practice policy to provide this training on an annual basis. The principal dentists we spoke with knew the location of all the emergency equipment and medicines and how to use them.

Are services safe?

Staff recruitment

The practice staffing comprised two principal dentists and two part-time trainee dental nurses. A visiting implantologist and an orthodontist also undertook occasional work at the practice. There was an up to date recruitment policy which included pre-employment checks. We reviewed the staff files and saw that the practice carried out some relevant checks to ensure that the person being recruited was suitable and competent for the role. This included the checking of qualifications, identification, registration with the General Dental Council (where relevant) and checks with the Disclosure and Barring Service (DBS). However, we noted that the practice had not kept copies of references for all members of staff and we were told some references were obtained verbally but not recorded. We did not see evidence of references for the two part-time trainee dental nurses, or the visiting implantologist and orthodontist. In addition there was no written contract on file for the two visiting staff.

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 carried out a number of risk assessments in order to identify and manage risks to patients and staff. For example, we saw risk assessments for fire and general health and safety completed in January and March 2015 respectively. The practice carried out monthly safety checks of fire extinguishers and undertook six monthly fire evacuation drills and we saw the records for these.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. The risk assessment had been completed in April 2014 and reviewed in April 2015. We saw that COSHH products were securely stored.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts arrived via email to the practice partners who then disseminated these alerts to the other staff, where appropriate. They also followed the MHRA on social media and used this as an alternative means of dissemination to staff.

The practice had a business continuity plan in place to ensure continuity of care in the event of a major disruption to the service. This included the facility for using an alternative practice nearby if the service suffered an unforeseen closure.

Infection control

There was an infection control policy in place including procedures to ensure infection control standards were met. These included procedures to follow for hand hygiene, managing waste and the decontamination of dental instruments. The practice followed guidance about decontamination and infection control issued by the Department of Health; 'Health Technical Memorandum 01-05 – Decontamination in primary care dental practices (HTM 01-05)' and the 'Code of Practice about the prevention and control of infections and related guidance'.

Posters about good hand hygiene were available to support staff in following practice procedures. Staff also had access to information about the practice protocol for dental instrument decontamination.

During our inspection we noted that the treatment room was visibly clean. The practice was currently undergoing refurbishment and extension with a separate decontamination room planned. At the time of our inspection the decontamination of instruments was performed in the surgery, the only room available, which was a good size. There were clearly defined and marked clean and dirty zones and flow with direction arrows to avoid decontamination.

The registered manager showed us the procedures involved in manually cleaning, rinsing, inspecting, sterilising, packaging and storing dental instruments including the use of a single autoclave. The procedures were in most respects completed in accordance with current guidance. However we did find the practice was storing some loose items in drawers in the 'splatter' zone (spray and other biological debris) which was unnecessary as they could be stored away from there or in lidded boxes .The registered manager undertook to address this immediately. Staff wore personal protective equipment (PPE) whilst decontaminating used dental instruments including eye protection, heavy duty gloves, aprons and face masks.

The practice had procedures in place for daily, weekly, monthly, quarterly and annual quality testing of the

Are services safe?

decontamination equipment including the autoclaves and we saw records to confirm these tests had taken place. Data from the observed cycle of the autoclave was logged each morning. However, as the data logger was only down loaded weekly, sterilisation cycle time temperature, steam (TST) strips needed to be used and retained with the observed autoclave cycles, to comply with current guidance.

Records showed a risk assessment for Legionella had been carried out in March 2013 by an external environmental company. (Legionella is a germ found in the environment which can contaminate water systems in buildings). This ensured the risks of Legionella bacteria developing in the water systems including the dental units within the premises were monitored. Preventative measures had been recommended to minimise the risk to patients and staff of developing Legionnaires disease. For example, there was a robust protocol for dental unit water line (DUWL) flushing for three minutes each morning then for 30 seconds between each patient.

We found waste was separated into appropriate containers and waste sacks, for disposal by a professional waste company. Waste documentation was detailed and up to date and we saw the consignment notes for this.

The practice had audited its infection control procedures in April 2015 to assess compliance with HTM 01-05.

All of the 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

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, autoclaves, washer disinfector and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety. Implant equipment was always brought in by the visiting specialist.

Medicines stored in the practice were reviewed regularly to ensure they were not kept or used beyond their expiry dates. Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients. However, some were stored loose in drawers in the surgery.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed in the area where X-rays were used. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales and there was an inventory of all X-ray equipment. One of the principal dentists was the radiation protection supervisor (RPS). All clinical staff including the RPS had completed radiation training. X-rays were graded and audited six-monthly to monitor their quality.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection we checked dental care records to confirm the findings and discussed patient care with the registered manager. We found that the dentists regularly assessed patient's oral health including soft tissues. Dentists 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 dentists always checked people's medical history and medicines prior to treatment. We saw from records this was signed by the patient and dentist at every check-up.

The records showed that an assessment of periodontal tissues was periodically 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 need in relation to a patient's gums). Gum disease was diagnosed via examination, recording the BPEs and X-rays looking for bone levels. This was all notated in the records seen. There were trigger levels for full gum pocket charting, prompting multiple visits and advice to patients on oral hygiene and diet.

The dentists kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the dentists referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to patient recall intervals and antibiotic prescribing. The practice kept up to date with other important guidance such as the Department of Health guidance for infection prevention and control.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. Smoking cessation advice was given for identified smokers and some patients were directed to the local community walk-in centre for further advice and follow up. Dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting area and in the consulting and treatment room. This was supported by information on the practice's website, including advice on gum hygiene and treatment, the use of mouth guards, bad breath and dentures, as well as preventative dentistry the practice offered.

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. The recently recruited trainee nurses had not yet undertaken formal training in safeguarding of children, infection control and fire safety beyond instruction given during induction and regular in-house update sessions. However, the registered manager told us this would be arranged and both trainees would be covering these topics in their dental nurse training course. The registered manager also told us there were sufficient staff to meet needs and staff were always available to cover absences such as annual leave and sickness.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interests of the patient. For example, there was a referrals policy under which referrals were made to specialist dental services, such as the visiting implantologist and orthodontist. The practice also referred patients to a local provider for specialist tests such as orthopantomogram (OPG) tests (whole mouth x-rays) and computed tomography (CT) scans (to provide images of dental structures, soft tissues, nerve paths and bone to enable more precise treatment planning). Children were referred to specialist paediatric services for some complex dentistry. We saw the referral log kept by the practice and examples of referral letters and electronic communications, which were appropriately detailed.

Consent to care and treatment

The registered manager explained to us how consent was obtained from patients for all care and treatment. Dental care records we checked showed consent had been gained before treatment began. There was evidence that

Are services effective?

(for example, treatment is effective)

treatment options, risks, benefits and costs were discussed with the patient and then documented in a written treatment plan. CQC comment cards which had been completed prior to our inspection indicated that patients were given treatment options and they were satisfied that their consent had been sought. We noted that the practice took particular care with anxious patients and it was practice policy to phone nervous patients after their treatment to check on their wellbeing.

The two principal dentists we spoke with demonstrated an understanding of the Mental Capacity Act 2005 and how this applied in considering whether or not patients had the capacity to consent to dental treatment. The Mental Capacity Act 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 had not attended formal training in the Mental Capacity Act 2005 but in-house instruction had been provided and we saw the minutes of the staff meeting in January 2015 when this took place. There was also guidance in a laminated quick reference guide for staff available at the reception desk. This included medical ethics and law notes on 'capacity for consent made simple.'

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We looked at 21 Care Quality Commission (CQC) comment cards patients had completed prior to the inspection. Patient feedback was very positive about the care they received from the practice. They commented that they were treated with respect, dignity, compassion and empathy.

Patients' dental care records were stored securely in locked cabinets.

The practice aimed to provide appointments with sufficient time between them to avoid overlap of patients and maintain privacy at the reception desk. The principal dentists we spoke with were aware of the importance of providing patients with privacy and ensured if patients wanted a confidential conversation away from the reception area this was conducted in privacy in the treatment room. The registered manager assured us the treatment room door was closed during treatments and feedback in CQC comment cards confirmed staff were polite and helpful with patients.

Involvement in decisions about care and treatment

We found in the dental care records we checked that patients were always given a copy of their treatment plan and associated costs and they were allowed time to consider the different options before going ahead with treatment. We noted that the practice used intra-oral photography frequently to show patients procedures if they wished and for treatment planning. CQC comment cards reported that patients had been involved in decisions about their care and treatment. Patients stated that treatment options were clearly explained; the dentists listened to and understood their concerns, and respected their choices regarding treatment.

There was information on the practice website about the range of treatments available and costs, including payment plans and options. Details of fees were also available at the reception.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered, on their website and in the patient waiting area. We found the practice had an efficient appointment system in place to respond to patients' needs. It was practice policy to leave gaps between patient appointments to allow as long as was needed for discussions to take place. The registered manager told us that patients in need of urgent treatment would be seen immediately and an emergency appointment slot was kept available for this. The practice website advised patients of this, including the availability of emergency treatment at weekends. We were also told of a case where non-urgent treatment was provided at the weekend. The patient emailed the practice on a Friday and was seen on the Sunday. Patients told us through CQC comment cards that they were happy with the appointment system and reported that appointments were unhurried and always easy to get. In the most recent patient satisfaction survey the majority of the respondents were very satisfied with the appointments system.

Tackling inequity and promoting equality

The practice was unable to offer full access for disabled patients due to the small confines of the premises. However, plans were in place to extend the practice premises to achieve this. The practice had an equality and diversity policy. Staff had not received formal training in equality and diversity issues but had been made aware of the practice policy and had discussed it at practice meetings. Staff spoke a range of different languages (Arabic, Spanish, French and German) and also had access to a translation service.

Access to the service

The practice was open Monday from 9.00am to 8.00pm and Tuesday to Friday from 9.00am to 6.00pm. The practice was closed at weekends but would offer an appointment on Saturday or Sunday if a patient required emergency treatment. The practice displayed its opening hours at their premises and on the practice website.

Feedback from CQC comment cards and patient surveys indicated that patients could get an appointment in good time and did not have any concerns about accessing the dentists.

Concerns & complaints

The practice had a complaints policy and procedure in place which provided staff with guidance on how to support patients who wanted to make a complaint. This included details of organisations with whom patients could pursue matters further if they were not satisfied with the practice's handling of their complaint. There was also a flow chart in the staff quick reference guide kept at reception to assist staff in handling concerns with a view to avoiding a formal complaint arising. Information about the practice's complaints policy was available at reception and on the website for patients to access. One of the dentist partners was the lead for complaints handling.

We found there was a system in place to investigate and communicate with patients regarding complaints which provided for an investigation and timely response. However, there had been no formal complaints since the practice had been in operation.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the service and ensured there were systems to monitor the quality of the service and make improvements where necessary. The practice manager led on individual aspects of governance such as safeguarding, information governance, infection control and health and safety. The practice held monthly meetings which involved the whole dental team and meeting minutes were retained. There were also regular informal meetings to discuss day to day issues. We found all the practice's policies were up to date and had been reviewed in the last year. We saw from the minutes of practice meetings that policies were regularly reviewed to ensure staff were aware of and understood them.

Leadership, openness and transparency

The two principal dentists we spoke with described a transparent culture which encouraged candour, openness and honesty. They encouraged staff to raise any concerns or issues with the registered manager. At team meetings staff were encouraged to put forward ideas and we saw from minutes that they were kept fully informed of important issues and developments. For example, staff working hours were reviewed at the team meeting in March and additional staff recruitment agreed.

The practice had a mission statement set out in the patient information leaflet; 'our aim is to provide quality dentistry within a gentle, personal and caring environment, dedicated to the long term health and comfort of our patients.' ' This was communicated to staff during induction and reviewed periodically, for example when discussing future strategy at a team meeting in June 2015.

There was a system of staff appraisals to support staff in carrying out their roles to meet patients' needs. Notes from these appraisals demonstrated that they successfully identified staff's training and development needs. They also indicated that staff were happy with their work and the support they received.

Learning and improvement

All staff were supported to pursue development opportunities. We saw evidence that the dentists were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice undertook regular audits. These included audits for infection control and X-ray quality.

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

The practice had systems in place to seek feedback from patients using the service, including carrying out patient surveys and inviting email feedback via the practice website.

The most recent patient survey carried out in 2015 showed a good level of satisfaction with the quality of service provided. All of the feedback from the survey had been very positive and patients had identified no areas for improvement. The practice nevertheless responded to feedback where appropriate. For example, one patient mentioned at an appointment that there were too many leaflets in the reception area, so the practice reduced the number of these and placed some in the treatment room.