Catherine Street Surgery

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Catherine Street Surgery is located in a two storey building in the centre of Whitehaven. The practice has two female General Practitioners (GPs) and employ a male locum GP on a regular basis. In addition the practice employ two practice nurses, a health care assistant and administration/reception staff.

The provider was registered to carry out the following regulated activities:

- Diagnostic and screening procedures

- Maternity and midwifery

- Surgical procedures

- Treatment of disease, disorder or injury

We carried out the inspection as part of our new inspection programme to test our approach going forward.

Patients we spoke with told us they were happy with the care and treatment they received. However,some people told us they were unhappy with the length of time they had to wait when attending the practice for an appointment.

The provider had a robust recruitment policy in place which included carrying our relevant checks prior to new members of staff being employed. For example, reference requests and ensuring clinical staff were registered with the appropriate professional bodies.

We found the provider had processes in place to monitor the quality of care being delivered, however these were not followed by some staff members within the practice.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Overall the service was safe. The patients we spoke with told us they felt safe and could get an appointment when they required one. Staff took an active role in delivering and promoting safety, learning and involvement. Patients were protected from abuse because the provider had suitable policies and procedures in place.

Are services effective?
Overall the service was effective. There were effective systems in place for managing, monitoring and improving outcomes for people. We found the GPs and Nurses were proactive in their roles around health promotion. Staff employed to work within the practice were appropriately qualified and competent to carry out their roles effectively. People received care, treatment and support that achieved good outcomes and promoted good quality of life.

Are services caring?
Overall the service was caring. Patients we spoke with who used the service were generally happy with their experience when they attended Catherine Street Surgery.They said staff treated them with dignity and they had no concerns around confidentiality.

Are services responsive to people's needs?
Overall the service was responsive to people's needs. We saw the provider had a comprehensive complaints procedure and complaints were responded to in a timely manner. We saw evidence of changes the provider had made in response to comments from patients.

Are services well-led?
Overall the service was not well-led. Although the provider had processes in place to audit stock levels and expriy dates of emergency medication and clinical equipment, we saw that these had not taken place frequently enough. We were unable to see any documented evidence of clinical audits having been undertaken.

Summary of findings

What people who use the service say

We spoke with seven patients who used the service and generally their comments were positive. They said the staff treated them with respect and dignity. Patients told us they were able to get an appointment when they needed one. However, some patients did state their views about having to wait for long periods when attending the practice for appointments. We looked at the results of a patient survey held in April 2014, generally the results were positive and showed a positive attitude towards the provider and the service they provided.

Comments cards had been left by the CQC to enable patients to record their views on the service. We found there was one completed comment card which referred to the length of time the patient had to wait to when visiting the practice for an appointment.

Areas for improvement

Action the service MUST take to improve

The provider did not have appropriate processes in place to ensure clinical equipment and emergency medication were available or in date. Although checks were undertaken we found that some emergency medication had passed the expiry date and some of the clinical equipment stored in sterile packaging had also passed the expiry date. This meant the provider did not have adequate systems in place for conducting internal audits.

We saw evidence of some medication audits undertaken by the provider but we did not see any evidence of clinical audits.

Regulation 10 (1), (a), (b)

Action the service COULD take to improve

We found that patients were not happy with the length of time they had to wait when attending the practice for an appointment. Some of the patients we spoke with told us they had been made to wait up to two hours to see the GP.

The practice did not have a patient reference group. This meant the provider could miss an opportunity to engage with patients and gain feedback and involvement on how to shape the service.

Good practice

Our inspection team highlighted the following areas of good practice:

The provider had recruited a co-ordinator to work with patients who may be mildly or moderately at risk of falls and did not currently have input from other clinical services such as District Nurses or Community Matron.

This was a non-clinical role focusing on providing support and social input to patients who were not accessing services. This would ensure the provider were able to engage with elderly or frail patients who did not access the service for health related reasons.

Catherine Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, an additional CQC Inspector, a GP and a practice manager. The team spent six hours inspecting the service and spoke with five staff and seven patients visiting the service.

Background to Catherine Street Surgery

Catherine Street Surgery is situated in Whitehaven, Cumbria. It provides primary care to approximately 2,752 patients.

The provider offered a range of book on the day and book in advance appointments between the hours of 9.00-11.20am and 3.00-5.30pm. In addition, the provider also offered extended hours on a Thursday evening from 6.30-8.00pm. When the practice was not open, out of hours cover was provided by Cumbria Health On Call.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service.

We carried out an announced visit on 13 May 2014. During our visit we conducted a tour of the premises. We also spoke with a range of staff which included GPs at the practice, the practice manager, receptionists and nurses and spoke with patients who used the service. We observed how people were being cared for and how staff interacted with patients. We reviewed information that had been provided by the provider and looked at the practice's policies and procedures. We reviewed other information that was available in the public domain.

Are services safe?

Summary of findings

Overall the service was safe.

Patients were protected from harm and abuse because suitable policies and procedures were in place, which enabled them to recognise and act on any event or incident and lessons learned were shared with all staff. The provider had systems in place to safeguard vulnerable patients from the risk of harm.

Our findings

Safe Patient Care

We spoke with patients who used the service who told us they felt safe and could get an appointment to see the GPs and nurses when they required one. The patients we spoke with did not raise any concerns about their safety.

Feedback from a patient survey undertaken by the practice was generally positive about the care they received.

Comments cards had been left by the CQC to enable patients to record their views on the service. We found that one had been completed and stated “The staff are great and listen to everyone. The only complaint I have is the wait for an appointment.”

We spoke with the practice manager who explained that there had been some delays when patients attended the practice for their appointment. This was due to a new GP joining the practice and taking longer for appointments to enable her to get to know the patient, their background and medical history.

Learning from incidents

The practice had a process in place for logging incidents and accidents.

We were able to review a summary of incidents reported and this included lessons learned and action taken to avoid reoccurance. Some of the staff members we spoke with were able to give an example of incidents that had occurred and the action they had taken to deal with them.

We spoke with the practice manager who told us the practice met on an annual basis and held a review of incidents that had occurred within the last 12 months, however we were unable to review minutes from the meetings.

Safeguarding

The provider had a safeguarding policy in place which had been reviewed and signed by staff. This contained details of external agencies for staff to contact should any concerns be raised. We spoke with reception staff who had a clear understanding of who the safeguarding lead was and what to do if they were concerned a child or adult was at risk of abuse.

Are services safe?

The provider had a dedicated safeguarding lead who had undertaken level 3 safeguarding training. We were able to look at the staff training matrix and saw that all staff had undertaken safeguarding training.

We spoke with a GP who told us that the practice followed the Royal College of General Practitioners Safeguarding Toolkit for dealing with any concerns relating to abuse.

We reviewed two staff files. We saw evidence of a DBS check in the clinical staff file we reviewed and saw that the DBS application process was in place for the non-clinical staff member. This meant that the provider took steps to ensure staff working within the practice did not have any convictions or cautions which prevented them from working with vulnerable adults of children.

Monitoring safety and responding to risk

We saw evidence the provider had procedures in place to deal with significant events. For example, problems with the District Nursing team attending multidisciplinary team meetings and visiting patients at home to take bloods. We saw that appropriate actions had been taken in an attempt to reduce the likelihood of reoccurrence.

We spoke with the practice manager who told us that information was shared with staff members at the time of the incident and during an annual review meeting. However these meetings were not minuted.

We spoke with staff and saw evidence that staff had been trained in how to deal with medical emergencies which included resuscitation. This meant that patients could be assured that there were sufficiently trained staff to deal with an emergency occurring within the practice.

We saw that fire exits were clearly signposted to enable staff and patients to exit the building safely.

We spoke with the practice manager who told us that all staff received practical fire safety training on an annual basis. We were able to review staff training records which supported this.

Medicines Management

The practice manager was a registered nurse and worked at the practice as a medicines manager on a part time basis. This role involved looking at the safety aspects of patients medication, including liaising with local chemists and supporting patients using medication. They told us they looked at patients on an individual basis. For example; looking at medication administration record charts of patients in nursing homes and ensuring relevant blood tests had been carried out..

We spoke with a GP who was able to give an example of a patient who had been prescribed a drug from a consultant which would not be suitable due to a chronic condition. This had been identified and appropriate action taken to avoid risk of harm to the patient.

We spoke with reception staff who told us that repeat prescriptions were monitored for over or under usage. There was a form in place within the practice that staff used to document any concerns about requests for medication.

We spoke with the Health Care Assistant who told us they were responsible for monitoring and recording fridge stock and temperatures. We carried out a random sample and saw that medication contained within the fridge was in date.

We reviewed the emergency drugs trolley and saw that some medication had passed its expiry date and the trolley did not contain a supply of Adrenalin. The Standard Operating Procedure for emergency drugs stated that checks should be carried out every three months. The last check had been undertaken in March 2014, however items of medication had expired in April 2014. We spoke with the practice manager following our inspection who told us the expired medication and adrenalin had already been ordered and received by the practice but were being stored in the drugs cabinet.

Cleanliness and infection control

We observed that despite the provider operating from an older building, all areas were visibly clean. We saw hand sanitising liquids were located close to the sinks and hand hygiene guidance was available next to the majority of sinks within the practice. Personal protective equipment (PPE) was available in clinical rooms, with disposable curtains around treatment couches.

We saw that clinical waste was disposed of and stored appropriately and sharps bins were present in the clinical rooms.

We reviewed an infection control audit which had been carried out by the practice. This looked at infection control of the building such as flooring and wall coverings. We saw

Are services safe?

the provider had identified areas for action, for example redecorating one of the treatment rooms. We looked around the premises and saw that these actions had been taken.

We spoke with the practice manager and asked how they dealt with samples brought in by the patients. They told us that samples were placed into a cabinet in the waiting area. This highlighted concerns around patient confidentiality as the cabinet was accessible to anyone entering the waiting area. We discussed this with the practice manager during our inspection who advised us that this would be reviewed.

Staffing and recruitment

The provider had an up to date recruitment policy which detailed the checks taken when recruiting new members of staff. This included checking professional registration for clinical staff and obtaining references from previous employers. We saw the provider had obtained Disclosure and Barring (DBS) checks for staff, however the recruitment policy still made reference to the Independent Safeguarding Authority (ISA).

We were able to review two clinical files and saw that these contained a record of registration with the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). The GMC and NMC are professional regulators that clinical staff are required to be registered with.

We spoke with the reception manager who told us that they monitored staffing levels regularly to ensure adequate cover was available.

The practice held two appointments on a daily basis to deal with any patient requiring an emergency appointment and if these were used then any additional emergencies would be added to the end of the clinical session. The people we spoke with told us they could get an appointment in an emergency. This meant that patients received safe care as they would be seen by a clinician on the same day.

Dealing with Emergencies

Equipment for dealing with medical emergencies was seen to be available within the practice, including emergency medicines. Staff we spoke with confirmed they had received training and knew how to deal with medical emergencies which included resuscitation.

Equipment

We saw evidence to confirm the maintenance of equipment was carried out and this included service contracts and calibration testing to ensure it continued to be in working order and fit for purpose.

We spoke with the practice manager who told us that daily checks were undertaken on the defibrillator to ensure this was ready for use.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective.

Care and treatment was delivered in line with best practice guidelines. Clinicians were able to prioritise patients and make use of available resources. We found there was no untoward comments from the current commissioner of care and services offered by the practice.

Our findings

Promoting best practice

We spoke with two GPs who told us how they obtained consent for various procedures. For example; written consent is obtained for minor surgery or contraceptive procedures and verbal consent obtained for examinations and referrals.

We spoke with the Health Care Assistant who told us that all new patients were assessed by the Practice Nurse and a new patient questionnaire would be completed to ensure all medical history was captured.

We were able to review performance information regarding management of Long Terms Conditions such as asthma and diabetes. The practice manager told us they had a system in place to encourage patients to attend for review appointments. This included sending recall letters to patients and having dedicated administration staff to follow up on patient recalls. If a patient repeatedly did not attend for a review then a major alert would be added to their clinical notes to enable the clinical staff to follow up opportunistically.

Management, monitoring and improving outcomes for people

We saw the provider had an action plan in place which outlined steps they were looking at to improve patient care. For example, introducing care planning around preventative care and looking into care bundles to manage chronic diseases.

We spoke with the practice manager who told us they had identified audits to carry out in areas in which they had been underperforming. For example, they told us they were looking at the use of specific medications where they were prescribing more than the national average and looking at ways in which this could be reduced and alternatives that may be more suitable to patients.

The information we reviewed in preparation for the inspection indicated that there was a higher than expected number of patients attending the Accident and Emergency (A&E) department at the local hospital. We discussed this with the practice manager who told us they reviewed all A&E attendance and if the patient could have been seen by

Are services effective?

(for example, treatment is effective)

the practice then a letter was sent to advise them of this and to encourage them to attend the practice in future. This would ensure the patient was seen by the most appropriate professional.

We spoke with one GP who told us how they monitored two week cancer referrals to ensure patients were seen by the hospital within timescales. These were then discussed at Multi-Disciplinary Team meetings.

We saw the provider did not have adequate systems in place for conducting clinical audits. Although internal audits were conducted, these were ineffective as were not carried out frequently enough. The audits the provider had conducted did not demonstrate that the audit cycle had been completed as they did not identify actions for improvement or changes to how the service would be run in order to improve findings. We spoke with two GPs who were able to tell us about clinical audits they had conducted, however we were unable to see any documented evidence of this.

Staffing

Patients were cared for by suitably qualified, skilled and experienced staff. The provider had completed relevant checks before staff started work. There was a recruitment and selection policy which the provider used when they recruited new staff.

We spoke with two GPs who had recently been appraised. One GP had been through the revalidation process and the other was due to be revalidated in June 2014. All GPs are required to go through the revalidation process in order to assure the GMC that they are up to date and fit to practice.

We spoke with the nurse, the health care assistant and members of the reception team who told us they were fully supported by the provider to attend training courses. We were able to review a staff training matrix which identified statutory and mandatory training for all job roles. We spoke with the practice manager who told us that all staff had an annual appraisal.

Working with other services

We spoke with the practice manager who told us they encouraged team work by holding regular multidisciplinary team meetings. They told us that these were regularly attended by the McMillan nurse, however they had struggled to engage with the district nursing team and health visitors.

We spoke with a GP who told us they were a member of the CCG board and attended local meetings.

Health, promotion and prevention

The provider had recently recruited a co-ordinator to work with patients who may be mildly or moderately at risk of falls. This role focused on patients who did not have input from other clinical services such as Community Matrons and District Nursing. We were unable to speak with the co-ordinator at the time of our inspection however the practice manager told us that they were currently looking at patients over the age of seventy five who had not visited the practice and assessing whether input was needed.

We found the GPs and Nurses were proactive in their roles and gave advice regarding diet and smoking on an opportunistic basis when patients attended for appointments.

We saw that there was health promotion information available throughout the practice, for example chlamydia screening information in the public toilets. We saw information available for patients in the waiting area.

We spoke with two GPs who told us how they tried to identify carers through discussions during consultation. Carers were then advised of support available and signposted to other agencies such as social services.

Are services caring?

Summary of findings

Overall the service was caring.

People we spoke with who used the service were generally positive of their experience when they used Catherine Street Surgery. They found the staff, friendly, approachable, they felt they responded to their needs and were caring. Staff respected their dignity and we observed reception staff speaking to patients in a caring way. We saw evidence of patient surveys carried out by the provider in April 2014. Generally the results were positive and showed a positive attitude towards the provider and the service they provided.

Our findings

Respect, dignity, compassion and empathy

We were able to review the findings from a recent patient survey which had been undertaken by the provider. People were asked, "Are the reception staff helpful." They rated the service highly and 35 (97%) people recorded their response as yes.

We spoke with seven patients who used the service who told us the staff were kind and caring. Comments included;

"The GPs are really nice and speak with you really nicely. I have no concerns at all."

"They treat me with dignity. I have no issues at all."

"They treat me with dignity. I have no concerns around confidentiality."

We saw that the practice had installed an additional telephone line, located away from the reception desk. This was to ensure that reception staff could maintain confidentiality when having conversations with patients.

Consultations took place in rooms which had a consulting couch for examinations and suitable disposable curtains which offered protection for their privacy and dignity.

We spoke with the practice manager who told us they recruited a regular male locum GP as the two partners at the practice were female. This meant that any patient wishing to be seen by a male GP had the opportunity to do so on a weekly basis.

Involvement in decisions and consent

When we reviewed the findings from the patient survey we saw that people were asked "Did you find the doctor helpful and informative about your treatment." We saw that 100% of people had recorded their response as yes.

We spoke with seven patients who used the service and told us they felt involved in decisions about their care and treatment. One person told us the doctor provided them with lots of information relating to their care.

We spoke with two GPs who told us how they recorded consent. This was obtained verbally for examinations and referrals but written consent was obtained for any minor sugery or contraceptive procedures.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to people's needs.

Patients we spoke with told us they were able to access an appointment when they needed one. However, some patients told us they had to wait for long periods when attending the practice for an appointment.

We saw that changes had been made a result of patient feedback.

Our findings

Responding to and meeting people's needs

The provider held a yearly patient feedback questionnaire and generally the comments were positive. There was also provision where patients could complete comments about the service they received in the waiting area.

We spoke with the practice manager and members of the reception team who told us how they had tried to manage feedback from patients regarding the length of time they had to wait when attending the practice for an appointment. For example; alerts were added to the clinical system for patients who had complex health needs, this meant that reception staff were able to book longer appointments.

We spoke with a GP who told us patients with long term conditions such as Asthma and Diabetes were monitored by the nurse. They told us that dedicated clinics were not offered as patients preferred to be able to come on different days of the week.

We spoke with the practice manager and asked what changes had been made to accommodate patients needs. They told us they had made changes to the way in which repeat prescriptions could be ordered. Repeat prescriptions could be ordered via a dedicated telephone line, the practice website or by bringing the request into the practice. They told us that feedback from patients had been positive.

We spoke with seven patients who told us they were happy with the service they received. One person told us; "Everytime I ring I get an appointment. I can get my blood test results on line and the GP rings me."

Access to the service

Catherine Street Surgery was located in a two storey building. There were waiting areas and consultation rooms located on the ground floor and the first floor. This was to ensure patients with mobility difficulties could access the service.

We spoke to seven patients who told us they could always get an appointment at the practice and sometimes this was the same day. However, they raised isses around the length of time they had to wait to be seen by the GP when they arrived at the practice. We discussed this with the practice

Are services responsive to people's needs?

(for example, to feedback?)

manager during the inspection who explained that they were currently working to overcome this and had responded to patient feedback via NHS choices by advising patients when surgeries were running behind schedule.

The practice manager explained appointments were available to book in advance or book on the day. Two appointments were held back each day to deal with emergencies, however any patient requesting an emergency appointment would be added to the end of the clinical session.

We spoke with the reception manager who told us that access to appointments was reviewed with input from the GP, particularly prior to busy periods such as Christmas.

We observed a member of the reception team speaking with a patient. They offered the patient a choice of which GP to see and what time would be suitable. A range of appointments were offered to the patient.

Concerns and complaints

The practice had an effective complaints policy and procedure. We were able to review a summary of complaints received by the practice and saw that these had been responded to within timescales.

The practice leaflet contained details of how to make a complaint, however this was not on display in the waiting area and had to be requested from a member of the reception team.

We reviewed the practice website which provided patients with the opportunity to submit any comments or concerns electronically and there was a comments box located in the waiting area.

We were able to review a summary of complaints received and this included lessons learned and action taken to avoid reocurence.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

We found the service was not well led.

The provider had monitoring processes in place, however these were not followed by some members of staff within the practice.

Our findings

Leadership and culture

We spoke with the GP who told us he met regularly with the practice manager and other partners at the practice on a regular basis to discuss clinical problems and find a solution. However, these were informal meetings and not minuted.

We spoke with staff within the practice who were positive about the management of the service and felt supported to approach the GPs and practice manager.

Governance arrangements

The provider had procedures in place for checking and monitoring the emergency drugs trolley. We reviewed the standard operating procedure and found that this advised staff to check stock levels and expiry dates every three months. We looked at the record of checks that had been carried out and saw that the last check was conducted in March 2014. During the inspection we undertook a random sample of the emergency drugs and saw that some medication had expired in April 2014.

We looked at clinical instruments in the nurses room and found that some of these were passed the expiry date and were no longer sterile.

This meant that although the provider had processes in place, these were not adequate and could result in harm being caused to patients due to lack of monitoring and clear lines of accountability for checks to be undertaken.

We spoke with two GPs and the practice manager who were able to tell us about some of the audits the practice had undertaken. However, when we asked to review information collected and examples of changes as a result of these audits we found this information had not been well documented. This meant that information could be overlooked by some members of the clinical team.

Patient experience and involvement

There was evidence of a patient survey undertaken in April 2014, the provider had circulated this to 50 patients and received responses from 36 patients. We saw there was a a comments box in the waiting area for patients to give feedback. When we reviewed the practice website we saw there was an option to submit comments electronically. This ensured patients were given the opportunity to provide feedback about the service.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

We spoke with the practice manager who told us there was no patient reference group in place at the time of our inspection. This meant the provider could miss an opportunity to engage with patients and gain feedback and involvement on how to shape the service. The practice manager told us that they intended to establish a patient reference group in the near future.

Staff engagement and involvement

Staff said they were encouraged to learn and were given time to think about ways in which they could improve the service within their role.

We spoke with two GPs, the Practice Manager and members of the reception team who told us that they had regular practice meetings to discuss the service and any issues. However, we were unable to see any evidence of this such as minutes or agendas. This meant there was no accurate record of any issues discussed.

We saw evidence of and staff confirmed they received an annual appraisal which enabled them to discuss their performance and plan for future objectives. However, the practice manager had not been through the appraisal process. We discussed this with the practice manager during the inspection and were told that conversations had taken place regarding workload and priorities.

We spoke with the practice manager who told us they regularly met with peers within the Clinical Commissioning Group (CCG) to discuss incidents which could effect the locality, for example delayed communication from the hospital. This ensured that themes could be recognised and steps could be taken to reduce reoccurrence.

We spoke with a GP who told us they were involved with the local CCG and attended local Board Meetings. This ensured that the provider was kept up to date with any new initiatives and could share information with practice staff.

Learning and improvement

We saw that complaints and significant events were recorded electronically. They were reviewed annually by the practice team.

We spoke with the nurse and members of the reception team who told us they had dedicated time to support learning and improvement, this was refered to as protected learning time. We were able to review a plan of intended learning and saw that this included mandatory training such as practical fire training.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use the service and others were not protected against the risk of inappropriate or unsafe care and treatment as the provider did not have effective operation systems designed to enable the registered person to regularly assess and monitor the quality of services provided. Regulation 10 (1), (a), (b)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use the service and others were not protected against the risk of inappropriate or unsafe care and treatment as the provider did not have effective operation systems designed to enable the registered person to regularly assess and monitor the quality of services provided. Regulation 10 (1), (a), (b)

Regulated activity	Regulation
Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use the service and others were not protected against the risk of inappropriate or unsafe care

This section is primarily information for the provider

Compliance actions

and treatment as the provider did not have effective operation systems designed to enable the registered person to regularly assess and monitor the quality of services provided.

Regulation 10 (1), (a), (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use the service and others were not protected against the risk of inappropriate or unsafe care and treatment as the provider did not have effective operation systems designed to enable the registered person to regularly assess and monitor the quality of services provided. Regulation 10 (1), (a), (b)