Guy Barrington Staight

Guy Barrington Staight - Pelham Street

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 14 November 2017 and 6 December 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out two announced visits to this location as part of this inspection due to an unexpected absence from the inspection team on the first visit. We carried out a second visit in order to complete the inspection. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Our findings were:

Are services safe?

We found that this service was not providing safe services in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective services in accordance with the relevant regulations.

Are services caring?

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

Are services responsive?

We found that this service was providing responsive services in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led services in accordance with the relevant regulations.

Background

Guy Barrington Staight - Pelham Street (also known as The Staight Practice) is a private doctor's practice situated close to South Kensington tube station. The practice premises are located within a building that is primarily made up of residential apartments. The practice premises are located below street level and accessible via stairs only. The practice offers general medical services to adults and children, usually between 8.30am and 6.30pm on Mondays to Fridays. There are three general practitioners, two are part-time. One of the three practitioners is female. The GPs are supported by a technician who is a former nurse and a team of three administrators and receptionist. There are other services provided from the location, but these are out of scope for CQC registration including occupational health services provided to employees under arrangements made by

Summary of findings

their employer. Consultations and treatments are also provided by a physiotherapist, clinical psychologist, a nutritionist and podiatrist, all of which are exempt from CQC regulation.

The lead GP is the registered manager. A registered manager is a person who is registered with the Care Quality Commission 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 service is run.

Forty three people provided feedback about the service by completing comments cards. The feedback was entirely positive about the practice, its staff and the care and treatment received. We also spoke with six patients during our inspection, who all also gave entirely positive feedback about the practice.

Our key findings were:

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients' feedback indicated they were satisfied with care and treatment, facilities and staff at the practice.
- The practice ensured that care and treatment information was appropriately shared when people moved between services. When patient consent, their NHS GP if they had one was kept informed of the care and treatment they received.
- There was a strong focus on continuous learning and improvement among the clinical staff.

We identified regulations that were not being met and the provider must**:**

- Ensure care and treatment must be provided in a safe way for service users
- Ensure they have suitable systems and processes in place that assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others
- Ensure staff receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

You can see full details of the regulations not being met at the end of this report.

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

- Review their arrangements to meet the needs of patients whose first language was not English, make clear the physical access restrictions on their website and consider how to make improvements to support the service accessibility to patients with sensory deprivation. The provider should consider a Disability Access Assessment.

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 service was not providing safe services in accordance with the relevant regulations.

- Staff demonstrated that they understood their responsibilities in safeguarding children and vulnerable adults from abuse.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- However, we found areas where improvements must be made relating to the safe provision of treatment. This was because the provider did not have a health and safety policy that reflected their current arrangements, and improvements were needed to the management of uncollected prescriptions.
- The practice had systems, processes and practices in place to minimise risks to patient safety, but some improvements were needed.The practice's arrangements in relation to chaperones did not reflect published guidance and, non clinical staff had not received training safeguarding children and vulnerable adults.

Are services effective?

We found that this service was not providing effective services in accordance with the relevant regulations.

- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Clinical staff had the skills and knowledge to deliver effective care and treatment.
- We found areas where improvements must be made in relation to the provision of effective care. This was because the provider did not have appropriate arrangements in place to support non-clinical staff to carry out their role.

Are services caring?

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

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients feedback indicated they were satisfied with care and treatment, facilities and staff at the practice.

Are services responsive to people's needs?

We found that this service was providing responsive services in accordance with the relevant regulations.

- Patients we spoke with said they found it easy and convenient to make a GP appointment at the practice.
- There was continuity of care, patients saw their preferred GP.
- Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

We found that this service was not providing well-led services in accordance with the relevant regulations.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- There was a clear leadership structure and staff told us that thy felt supported by management. However the provider did not have formalised support, training, professional development, supervision and appraisals arrangements in place for the non-clinical staff team.
- The practice had policies and procedures to govern activity, although these were not consistently followed.
- The provider was aware of the requirements of the duty of candour.
- The lead GP encouraged a culture of openness and honesty.
- There was a focus on continuous learning and improvement among the clinical staff.

Guy Barrington Staight - Pelham Street

Detailed findings

Background to this inspection

We carried out two announced visits to this location as part of this inspection due to an unexpected absence from the inspection team on the first visit. The first visit was on 14 November 2017 which was carried out by a CQC inspector; with a second visit on 6 December 2017, which was led by a CQC inspector, and included a GP specialist advisor.

Before visiting, we reviewed a range of information we hold about the service. During our visit we:

- Spoke with the staff - the GPs and reception and administrative staff.
- Spoke with patients who used the service.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Reviewed service policies, procedures and other relevant documentation.
- Inspected the premises and equipment in use.

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

We found that this service was not providing safe services in accordance with the relevant regulations.

Safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety, but some improvements were needed.

- Arrangements for safeguarding people from abuse reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead GP was the lead member of staff for safeguarding children and vulnerable adults.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding, but non-clinical staff had not completed formal training in safeguarding people from abuse. On our second visit, the provider had prepared a training statement which details mandatory training topics for all staff, and included safeguarding training, but none of the training had been completed by staff. The provider told us they intended to begin the training from January 2018. Clinical staff had received training in safeguarding children and vulnerable adults relevant to their role, to adult and child safeguarding level three.
- A notice displayed next to the reception desk advised patients that chaperones were available if required. This information was also included in the new patient registration documentation. However the registration form on the provider website needed to be updated as it asked patients who needed it, to bring their own chaperones.
- The practice had a chaperone policy in place, which stated that all staff who acted as chaperones would receive training for the role. A member of the reception staff team confirmed that they would sometimes act as a chaperone, but they had not received training for the role and had not received a Disclosure and Barring Service (DBS) check, whilst in their current role although they told us they had had the training and background check in their previous role to this. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We saw records indicating all clinical staff in the practice had received DBS checks

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. A cleaning company was contracted to clean the practice premises on a nightly basis during the week
- The lead GP was the infection prevention and control (IPC) lead in the practice, and they had an IPC policy in place, which referred to the provision of staff training in IPC.
- The lead GP provided us with evidence of Legionella risk assessments carried out on the air conditioning system, but there was no legionella risk assessments of the water system in the premises. However they provided us with a copy of the cleaning and disinfection certificate for the building's water system.

We reviewed the personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references for non-clinical staff; and in addition to these qualifications, registration with the appropriate professional body and the appropriate checks through the DBS for clinical staff. Clinical staff were professionally registered and had arrangements in place for their ongoing revalidation.

Risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety, but some improvement was needed.

- The practice had up to date fire risk assessments. Fire extinguishing equipment and fire exit signage was in place in the practice. There was a fire evacuation plan.
- We saw records indicating clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- There was a health and safety policy available. However the policy referred to duties undertaken by the nurse,

Are services safe?

and there was no nurse employed in the practice. In addition the health and safety policy referred to staff training not included in their recently developed staff training statement.

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a defibrillator available on the premises and oxygen with adult and child masks.
- All clinical staff received basic life support training and there were medicines available for treating medical emergencies.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had business continuity plans in place for major incidents such as power failure or building damage.
- The clinical team were aware of the risks of sepsis in the general population, and symptoms to look out for in relation to this disease among their patient population. They had recently discussed risks of sepsis in children at a clinical meeting.
- The practice had professional indemnity insurance in place that protected the medical practitioners against claims such as in respect of medical malpractice and negligence

Information to deliver safe care and treatment

- The clinicians maintained comprehensive records that provided them with the information they needed to deliver safe care and treatment to people.
- Patient records were written to keep people safe. Information needed for care and treatment was available, including test results, assessments and notes. We saw that patient needs as appropriate were documented in their care records.
- The practice operated in a paper light way, where as much information as practicable was held electronically. They had sufficient storage available electronically, and for their paper records.
- The practice asked new patients to provide information to verify their identity.

Safe and appropriate use of medicines

The arrangements for managing medicines, including medicines used to treat medical emergencies, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal), although we found an area where improvement was required.

- The practice had a prescribing protocol and there were processes for handling repeat prescriptions. Repeat prescriptions were signed before being issued to patients and there was a reliable process to ensure this occurred.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- There was a policy in place for the management of the controlled drugs held in the premises, which complied with relevant legislation.
- However we found that the system for monitoring prescriptions that had not been collected needed to be improved. We saw uncollected prescriptions issued as long ago as May 2017, which had not been collected or followed up. We raised this with the lead GP, who said they would discuss this with staff ensure the uncollected prescriptions are reviewed monthly as per their prescribing policy

Track record on safety

There was a system for reporting and recording significant events.

- Staff told us they would inform the lead GP of any incidents
- From the documented example we reviewed, we saw that the provider had arrangements in place for managing significant events.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.

Lessons learned and improvements made

The provider was aware of the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was not providing effective services in accordance with the relevant regulations.

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- We saw evidence that clinical staff attended professional meetings and training events, where the latest best practices were discussed.
- Staff had access to guidelines from NICE and were meeting or exceeding the recommendations made in these guidelines.

Monitoring care and treatment

- The practice had arrangements in place to follow up patients that needed ongoing monitoring. They had systems to book in such patients for follow ups.
- We saw evidence of the clinicians participating in quality improvement initiatives, peer review and continuous professional development events. The practice GPs attended joint meetings with another practice every two months, where they regularly invited consultants and specialists to give talks on various conditions, guidelines and updates. They also discussed complex cases at these meetings.
- We saw evidence that the practice reviewed the effectiveness and appropriateness of the care provided. We saw that they carried out clinical audits and improvements were made as a result.
- The practice provided the summary of a clinical audit completed in the last two years, where the improvements made were implemented and monitored. The audit, initiated following clinical guidelines changes, was a review of the patients treated with Thyroxine, a medicine used used to treat an underactive thyroid. The audit found 64 patients were being treated with the medicine, and following the first cycle of the audit 24 patients (or 38%) had their dosage increased according to the new guidelines. The audit found on the second cycle that the patients who had had their dosage increased had improved thyroid stimulating hormone (TSH).

Effective staffing

Evidence reviewed showed that clinical staff had the skills and knowledge to deliver effective care and treatment.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for clinical staff reviewing patients with long-term conditions had received update training.
- Clinicians taking samples for cervical screening had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.
- We saw evidence that the GPs had arrangements in place for clinical supervision and facilitation and support for their revalidation.

However there were improvements needed to the support given to non-clinical staff to carry out their duties:

- The practice did not have an induction programme for newly appointed staff. The latest member of staff recruited was a member of the administrative team. They had not received training relevant to their role in topics, such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However they confirmed that they had received training in basic life support and they had shadowed a more experienced member of staff in the practice to gain competence in their role.
- The lead GP had recently developed a staff training statement which listed a number of topics all staff would complete to support them in their role. The training topics included computer training, infection prevention and control, and basic life support.
- There was no formal system of appraisals or review of staff development needs. Staff meetings were informal and mostly undocumented.
- A technician was employed in the practice, and carried out duties to support the clinicians such as audiometry, electrocardiogram (ECGs), lung function tests, measure fitness by rate of oxygen use, patient biometrics such as height, weight, percentage fat and blood pressure. Training had been on the job, led by the lead GP. However, the practice website and documentation within the practice referred to the member of staff as a practice nurse. Following receipt of the draft report of the inspection, the provider updated their website to

Are services effective?

(for example, treatment is effective)

refer to the member of staff as a healthcare assistant. The lead GP told us that the member of staff did not undertake any nursing duties, and our review of their appointments and consultations confirmed this.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice contracted out pathology services to a medical laboratory provider. We saw there were systems and processes in place for the collection of samples from the practice, and electronic sharing of test results.

We saw evidence that where appropriate, staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent. Where appropriate we saw there was correspondence with other health care professionals for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

We saw examples of how patients, with their consent, had information shared with their usual GP about the care and treatment they received. Patients we spoke with during our inspection also confirmed that this happened, and give examples of when they were referred to specialist secondary care, their NHS GP also received a copy of this referral for their information.

Supporting patients to live healthier lives

The practice encouraged patients to have the nationally recommended vaccinations through their NHS GP, if they had one. The practice was able to provide the full range of nationally recommended childhood, adult and travel vaccinations.

The practice offered cervical screening to women in the appropriate age range. The practice also provided patients with bowel and breast cancer screening. There were failsafe systems to ensure results were received for all samples sent and the practice followed up patients with abnormal results.

Patients had access to appropriate health assessments and checks, which were usually part of their initial consultations as new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GPs assessed the patient's capacity and, recorded the outcome of the assessment.

Are services caring?

Our findings

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

Kindness, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Patients could be treated by a clinician of the same sex.

Forty three Care Quality Commission comment card was completed, and the comments made were entirely positive about the care and treatment experiences, and interactions with staff. Patients told us they found the staff professional, friendly and helpful.

We spoke with six patients during our inspection. They all told us they were treated with kindness, respect and compassion. They told us they had and would continue to recommend the practice to other people.

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comments cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Privacy and Dignity

- Staff we spoke with during the inspection understood and respected people's privacy and dignity needs. The practice had arrangements in place to provide a chaperone to patients who needed one during consultations.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Information about people was treated confidentially.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was providing responsive services in accordance with the relevant regulations.

Responding to and meeting people's needs

The practice sought to meet the needs of its population:

- There were longer appointments available for patients who had that need, such as people with complex health needs or patients whose first language was not English.
- Home visits and same day appointments were available
- Patients were able to download the practice registration form, and request a repeat prescription from their website
- There was restricted access into the practice premises, as there was a flight of stairs descending to the entrance door from street level. The reception staff told us they would

help patients as much as possible if they needed that support accessing the premises

Timely access to the service

The practice was open Mondays to Fridays from 8.30am to 6.30pm. When the practice was closed, a doctor was available (on-call) to provide any necessary assistance. The telephone answering service directed patients how to contact the on call doctor.

Appointments were available booked in advance or on the same day. The practice offered appointments of 15 or 30 minutes, and patients were able to choose their preferred appointment length. Home visits were available to patients who had that need or preference.

Patients we spoke with on the day of the inspection told us on that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- It had a complaints policy and procedures in place
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. This included staff being able to signpost patients to the complaints process.

The practice had not received any complaints in the last 12 months.

Are services well-led?

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

Our findings

We found that this service was not providing well led services in accordance with the relevant regulations.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The Staight practice has been at its current site since 1994. In recent years the lead GP has been joined by two additional GPs; one of whom has been working in the practice for 12 years and the other for two years.
- The lead GP had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The lead GP was visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for its patients.

- The practice had a statement of purpose in place, which defined among its aims and objectives to provide high quality private general medical care for all patients registered with them.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The practice had a supportive culture towards staff and patients; however improvements were needed to staff support arrangements:

- Staff told us they felt supported and valued by the practice leadership. They told us the leadership was approachable and listened to them if they wanted to raise any matters.
- The practice had a policy in place in relation to Duty of Candour. The policy sought to encourage a culture of candour, openness and honesty.
- Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- The practice needs to implement processes for providing non-clinical staff with the development they need. This included staff appraisal and training.

Governance arrangements

The practice had governance arrangements in place as follows:

- The provider had suitable arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice had a range of policies and procedures in place; however some had only been recently developed and were yet to be implemented such as policies for infection prevention and control, and staff training. The lead GP told us they planned to start implementing these in the new year. Other policies and procedures were not consistently implemented and understood by staff, such as the procedures for dealing with uncollected prescriptions which were not being followed at the time of our inspection.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The lead GP was the information governance lead, with responsibilities for ensuring confidentiality, integrity and availability of data. The practice had a protocol in place for the management of patient data, and staff we spoke with were able to describe how they would ensure patient data was kept secure.

Engagement with patients, the public, staff and external partners

Are services well-led?

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

The practice had a protocol in place for raising staff concerns, which referred to a monthly meeting held in the practice. However they were only able to provide minutes of two meetings from the past 12 months. Staff told us the lead GP was very approachable and they would raise any issues with him, at the time they occurred. Matters discussed at practice meetings included appointments, staff cover and fees changes. The lead GP also told us that members of staff discussed issues in the practice on a daily basis due to them being a small team. They told us they had regular informal meetings between both the doctors and other staff, but that not all these meetings were minuted.

We saw meeting minutes which indicated that the clinical staff held regular joint meetings, every two months, with another practice. Guest speakers were regularly invited to these joint clinical meetings and they had given talks on a range of topics, guidelines and updates, including on CQC registration and inspection, pain management and shoulder problems.

The practice did not formally seek patient views, but they told us they received individual written compliments periodically. No complaints had been received in the 12 months prior to our inspection.

Continuous improvement and innovation

Clinicians in the practice were engaged in continuous professional development.

Clinicians in the practice participated in regular joint clinical meetings for peer support and professional development.

The lead GP told us that all staff received induction training and other training, as well as meetings with him on an ad hoc basis for their annual appraisal. The lead GP told us they did not keep records of the appraisal process but staff were informed of progress and any issues that may arise relating to their roles in the practice.

We saw evidence that the practice had consulted a training company in 2015 to review staff training in the practice, and help identify knowledge and skills gaps.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users, as the registered provider did not assess and mitigate the risks to the health and safety of service users of receiving the care or treatment; specifically in respect of health and safety risks and the management of uncollected prescriptions This is in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have suitable systems and processes in place that assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others; specifically as practice policies, processes and documentation were not consistently followed and kept up to date. This is in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider did not ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This is in breach of regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.