Petrie Tucker and Partners Limited

Lyndhurst Family Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 October 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 not providing well-led care in accordance with the relevant regulations

Background

We carried out a comprehensive inspection of Lyndhurst Family Dental Practice on 4 November 2015. The practice is a member of mydentist group and provides both NHS and private dental treatment to patients of all ages. The practice has six self-employed dentists, one dental therapist, and employs nine dental nurses, one trainee dental nurse, and a practice manager.

The practice manager 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 practice is run.

The practice operates over 2 floors in a four storey building converted from two houses. Access to the main reception area, one consultation room and patient toilet (suitable for disabled people) is on ground level, with three treatments rooms and waiting area accessible by a few steps. Additional surgeries, waiting area and patient

Summary of findings

toilet, not accessible to patients who cannot negotiate stairs, are located on the upper first floor and second floor. There is on street parking available around the building.

The practice is open Monday to Friday from 9.00am to 5.30pm, late opening for both NHS and private patients is offered, the times vary and displayed in the waiting areas. Domiciliary dentistry is offered to patients living in local care homes.

We spoke with four patients during our inspection and received four comments cards that had been completed by patients prior to our inspection. We received positive comments about the cleanliness of the premises, the empathy, and responsiveness of staff and the quality of treatment provided. Patients commented that the building is in need of refurbishment.

The patients we spoke with told us that staff explained treatment to them well and reported that the practice had seen them on the same day for emergency treatment. Patients commented that the service they received was good, and that they were always clear about the costs involved in their treatment.

Our key findings were:

- Poor maintenance of the building fabric, fixtures, and fittings had potentially compromised the practice's ability to comply with infection prevention standards.
- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, and assessing risks to staff and patients.
- Staff received training appropriate to their roles and supported in their continued professional development.
- There were sufficient numbers of staff to meet patients' needs.
- Patients' needs were assessed and care was planned in line with guidance from the National Institute for Health and Care Excellence (NICE).
- The practice sought feedback from staff and patients and used it to improve the service provided.
- There was a lack of clinical leadership and systems evident in the practice to ensure quality assurance of standards and processes.
- The assurance process for monitoring the quality of X-ray images was irregular and insufficient to reduce the risk of patients being subjected to further unnecessary X-rays.

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

- Ensure that the fabric of the building, fixtures, and fittings are maintained to comply with infection prevention standards.
- Strengthen quality assurances processes to ensure that standards are met to keep patients and staff safe.
- Ensure that all clinical waste is labelled and collected regularly.
- Ensure that regular quality checks of X-ray images are undertaken, recorded, where quality is poor, it is investigated, and changes made to ensure that patients are kept safe.
- Ensure accurate record keeping for changing of chemicals used in the X-ray developing machine.

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:

- Improve the system to ensure that learning from individuals, their audits, and reviews is recorded, shared, and available with the wider practice team.
- Strengthen the clinical leadership within the practice.

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.

Staff had received training in safeguarding, whistleblowing and knew the signs of abuse and who to report them to. Infection control procedures were good; however, infection prevention standards may have been compromised by poor maintenance of the building fabric, fixtures, and fittings. The equipment in general was well maintained. There were risk management processes in place to reduce harm to both staff and patients, however, poor maintenance of the building, fixtures, and fittings, which was the responsibility of mydentist may have compromised infection prevention standards.

Are services effective?

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

Patients received an assessment of their dental care needs including taking a medical history. Explanations were given to patients in a way they understood and risks, benefits and options available to them. Staff were supported through training, appraisals, and opportunities for development. Patients were referred to other services in a timely manner.

Are services caring?

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

Patients told us they had very positive experiences of the dental care provided at the practice and felt all members of staff treated them with respect and empathy. Patients felt involved in decisions about their treatment and that staff explained treatment to them in a way that they understood. Staff demonstrated how they were able to personalise their approach to patients which enable patients whose first language was not English easier access to dental care. Information about patients was treated confidentially.

Are services responsive to people's needs?

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

The practice offered a range of services to meet patients' needs, and provided emergency out of hours treatment for those that needed it.

Appointments were easy to book and the practice offered extended opening hours to meet the needs of those who could not attend during normal opening hours. The practice offered slots each day enabling responsive and efficient treatment of patients with urgent dental needs.

There was a clear complaints procedure and information about how to make a complaint was displayed in the waiting area.

Are services well-led?

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

We found that poor maintenance of the building fabric, fixtures, and fitting had potentially compromised the practice's ability to comply with infection prevention standards.

Summary of findings

Quality assurance systems needed to be strengthened to identify risks and to put measures in place that would keep patients safe. We found that the monthly checks for legionella testing had not been performed regularly. There was no robust system to ensure that clinical waste was well managed and collected appropriately. The quality assurance process to ensure that X-rays were developed to the required standard was not robust; this included the replacement of chemicals used within the developing machine.

Lyndhurst Family Dental Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 4 November 2015 and was conducted by a CQC inspector and two dental specialist advisors.

During the inspection we spoke with four dentists, four dental nurses, clinical support manager, and practice manager. We also spoke with four patients. We reviewed four comment cards about the quality of the service that patients had completed prior to our inspection. We reviewed policies, procedures and other documents relating to the management of the service.

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

The practice received national and local alerts relating to patient safety and safety of medicines. The practice manager and reception team received the alerts by email. The alert was printed and allocated to a dentist who recorded if any action was needed. For example, a medicine alert was received 22 June 2015, it was signed and annotated that no action was required on that same day by a dentist. The information was kept and was available to all staff.

Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). A needle stick injury had been recorded by a staff member and showed that the practice had managed the situation well, to minimise any risk to the staff member.

Reliable safety systems and processes (including safeguarding)

The practice had satisfactory child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting, and dealing with suspected abuse. The policies were readily available to staff and they had access to contact

details for both child protection and adult safeguarding teams in each treatment room and the staff room. Staff knew how to recognise signs of abuse in vulnerable adults and children, and all had completed the required training in child protection.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment.

We noted that there was good signage throughout the premises clearly indicating fire exits, the location of first aid kits, medical emergency equipment, and X-ray warning signs to ensure that patients and staff were protected.

Medical emergencies

The staff had received training in cardiopulmonary resuscitation and first aid and those we spoke with knew the location of all the emergency equipment in the practice. The staff told us if a patient was unwell, two dentists and a dental nurse formed the emergency team, once accessed the patient was cared for by the appropriate staff member.

We checked the emergency medical treatment kit available and found that this had been monitored regularly to ensure that it was fit for purpose. There was adequate equipment in place to deal with all medical emergencies as recommended by the Resuscitation Council (UK). For example there was an automated external defibrillator, blood glucose measurement device**,** and self-inflating bags. The staff we spoke with could describe the actions that would be needed in an emergency.

Emergency medicines, in line with guidelines issued by the British National Formulary were available to deal with a range of emergencies including angina, asthma, chest pain, and epilepsy, and all drugs were within date for safe use.

The location of first aid boxes and emergency equipment was clearly signposted.

Staff recruitment

We checked records for five staff members which contained evidence of their GDC registration, employment contract, job description, indemnity insurance, and a disclosure and barring check (DBS). The Disclosure and Barring Service carries out checks to 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. All new staff underwent an induction to their job which they reported had been useful.

Monitoring health & safety and responding to risks

The practice had comprehensive health and safety policies in place, which covered a range of issues including moving and handling, equipment, medicines and radiation. We found evidence that the practice conducted regular health and safety checks to ensure the environment was safe for both staff and patients. We were concerned that health and safety for patients and staff may have been compromised due to the poor maintenance of the building fabric, fixtures, and fittings.

Are services safe?

We spoke with staff who understood their role and responsibilities and had an awareness of fire safety. They had a clear plan of how to evacuate the building keeping patients safe in the event of a fire. On 3 November 2015, the practice fire wardens carried out a fire drill, including evacuation of patients. The practice is situated over four storeys; an evacuation time of three and a half minutes was recorded. The building was well signed posted and fire extinguishers had been checked.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included loss of utilities, fire, and flooding.

The document contained relevant contact details for staff to refer to. For example, contact details of equipment and IT suppliers and tradesmen. This plan was available off site through the company's main office.

Infection control

Patients who completed our comment cards reported that they always found the practice clean and had no concerns about cleanliness or infection control, but stated that it needed refurbishment.

We noted that the interior of the premises needed improvements to ensure that the practice was able to comply with infection control standards. In general, we found that the dental treatment areas, decontamination room, and the environment were visually clean, and tidy. However, some clinical rooms were in a worse condition, for example in a treatment room, we were concerned to see a significant sized hole in the plaster of the wall. We highlighted this to the manager who requested the maintenance department of mydentist to undertake urgent repairs; this was completed within two working days of the inspection.

The carpentry throughout all the clinical rooms was old and the protective laminate had worn away. The work surfaces were stained, in some rooms there was excessive electrical wiring on them. Sealant was discoloured and in places lifting.

An infection control audit was completed 6 May 2015; it identified that clinical areas needed improvement. Following the audit, an inspection by mydentist was carried out on the 26 May 2015 with a refurbishment plan produced. The staff told us that no date had been confirmed for the works to start. The refurbishment plans we saw, did not contain sufficient detail for us to be assured the work being carried out would address our concerns.

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the essential processes and practices to prevent the transmission of infections. Decontamination of dental instruments took place in a dedicated room in the practice. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures.

We found that in general the practice was meeting the HTM01- 05 essential requirements for decontamination in dental practices. We noted that some of the instruments appeared old and worn, therefore cleaning, and sterilising to the required standard was compromised. We highlighted this to the practice manager who took action to replace these. We found instruments in a treatment room that had cement adhered to them.

We observed the practice's processes for cleaning the premises. Regular inspections had taken place with checklists completed, for example cleaning of floors and surfaces daily.

The practice had a range of relevant written policies in place for the management of infection control including those for exposure to blood borne viruses, hand hygiene, and legionella management. A legionella risk assessment had been completed; however, staff had not regularly conducted monthly checks of water temperatures in the building as a precaution against the development of legionella. We were told that regular checks had been undertaken and recorded, however, staff had become confused about the process, had destroyed the records as a new system was implemented. The practice manager told us that training had been given and checks were now in place. Regular flushing of dental water lines was carried out as in accordance with current guidelines. Training files showed that staff employed at the practice had received appropriate training in infection prevention, however, the system to monitor quality assurance and drive improvements needed to be strengthened.

There was an audit to ensure substances hazardous to health were updated in the Control Of Substances

Are services safe?

Hazardous to Health (COSHH) file. Staff immunisation status in respect of Hepatitis B was recorded, and there were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument.

The nurse showed us how the practice checked that the autoclaves (equipment used to sterilise dental instruments), was working effectively. A daily visual observation check of the autoclaves was undertaken at the start of the day to check they were operating effectively.

We noted good infection control procedures during the patient consultation we observed. Staff's uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross infection. We saw both the dentists and dental nurses wore appropriate personal protective equipment and the patient was given eye protection to wear during their treatment. Following the consultation, we saw that the dental nurse wiped down all areas where there had been patient contact, as well as the dental hand pieces and the lamp.

An appropriate contractor was used to remove dental waste from the practice and we viewed the necessary waste consignment notices. We noted that spent chemical waste had last been collected in April 2015. Sharps boxes were sited safely, and assembled and labelled correctly. The waste was stored in an outside area, for fire prevention it was stored in a locked metal container. The bags were not labelled with the practice postcode, as required to identify the waste should an issue be raised prior to destruction. We noted one split bag with the content loose in the bin; this posed a risk to staff collecting the waste.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained, and serviced in line with the manufacturer's instructions. Records showed that the equipment was in good working order and being effectively maintained.

The test for portable electrical equipment to ensure its safety was carried out in July 2015. The dentist confirmed that any adverse drug reaction would be reported via British National Formulary yellow card scheme. This scheme collects information on suspected problems or incidents involving medicines.

Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Prescription pads were stored securely with a system in place to monitor their issue to prevent incidents of prescription fraud.

Radiography (X-rays)

The practice had appointed an external company as the Radiation Protection Adviser and had appointed all dentists/orthodontists as Supervisors, as required by the Ionising Regulations for Medical Exposure Regulations (IRMER) There was a well maintained radiation protection file which contained the required information including the local rules and inventory of equipment, critical examination packs for the X-ray machine and maintenance logs.

The practice monitored the quality of the X-rays images; however, we were concerned that the quality assurance process was irregular and insufficient to reduce the risk of patients being subjected to further unnecessary X-rays.

An audit of X-rays completed by a dentist detailed that some X-rays had not meet the standard required because of development issues. We reviewed the test X-ray images (Wedge Tests) which showed that some were of poor quality, we noted, on the day of the inspection, no records prior to September 2015 were available. The records of chemical (fixer and developer) changes were inconsistent.

We looked at a sample of dental care records where X-rays had been taken. These showed that the dentists recorded the reasons they had taken X-rays, and the results.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We saw that dental care records contained a written medical history obtained before starting to treat a patient. Patients we spoke with confirmed that these were updated regularly. Dental care records we viewed evidenced that NICE guidance was followed for the recall frequency, antibiotics prescribing, and the management of wisdom teeth.

Health promotion & prevention

There was a good selection of information leaflets including smoking cessation available for patients in the waiting areas. Staff we spoke with were aware of the importance of health promotion. Patients we spoke with told us that the dentist advised them on health promotion. For example three patients we spoke with had been given smoking cessation advice.

Dental care records we viewed did not always detail the discussion on health promotion.

Staffing

There were six self-employed, dentists (hours varied between 0.75 whole time equivalent (WTE) to full time, and a dental therapist (0.4 WTE). There were nine employed dental nurses (7.5 WTE). Three of these nurses also covered the reception duties. The practice manager had a dental nurse qualification, and was responsible for the management of the practice.

Records showed that the staff were up to date with their continuing professional development; (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of continuing professional development (CPD) to maintain their registration).

There was an established staff team at the practice and staff absences were planned for to ensure the service was uninterrupted. Agency dental nurses were used if needed. Staff told us there were enough of them to maintain the smooth running of the practice. Following extended leave, a well-managed and supportive return to work process, with appropriate adjustments to their role was in place.

All dental nurses and non-clinical staff received an annual appraisal of their performance and had personal development plans in place. The practice manager who assessed staff's performance in a range of areas carried out these appraisals.

Working with other services

Patients requiring specialised treatment such as complex restorative work, oral surgery, or pathology were referred to other dental specialists. We viewed a small sample of referral letters which were comprehensive and contained detailed information about patients' needs. A register of referrals sent and correspondence received was maintained. Staff checked this regularly and would follow up if required.

Consent to care and treatment

Dental care records we viewed demonstrated that patients' consent to their treatment had been obtained and that this was recorded. Dental nurses spoke knowledgeably about the importance of gaining patients' consent to their treatment, and told us that patients were always asked to sign relevant consent forms before their treatment took place. The practice held an NHS contract to provide domiciliary dentistry to the residents that lived in local care homes. The patients were given forms to obtain consent and up to date medical information prior to the visit. This enabled patients to discuss their wishes with staff, carers, or relatives and give informed consent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent comment cards to the practice for patients to use to tell us about their experience of the practice. We collected four completed cards in total. These provided a positive view of the service the practice provided. The practice had collected feedback from patients through the Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on the services provided.

Patients commented that staff were respectful, efficient, and empathetic to their needs. They commented that the dentist listen and put them at ease.

We spent time in the patient's waiting area and found the general atmosphere was welcoming and friendly. Staff were polite and helpful towards patients, both in person and on the phone.

Patient confidentiality was taken seriously; we noted that staff did not use more information that necessary when discussing next appointments or charges. If patients wanted to talk to reception staff in confidence they could be taken to another room.

The staff in the practice spoke eight different languages, enabling patients who did not have English as a first language to access dental care with ease.

Involvement in decisions about care and treatment

Patients we spoke with, and comments cards we received, indicated that patients felt they were involved in decisions about their dental care, and that the dentist explained treatments in a way that they could understand. They reported that the dental staff spoke to them throughout their treatment ensuring that they were comfortable. The dentist also gave out information leaflets to patients to help them better understand their treatment and oral health care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided a range of services to meet patients' needs. It offered both NHS and private treatment to children and adults.

There was good information for patients about the practice, available both in the waiting area and in the practice leaflet. This included details about the dental team, the services on offer, how to raise a complaint, and information for contacting the dentist in an emergency. Emergency and out of hours cover was provided and was accessed via 111. There was clear information about NHS and private costs on display in the waiting room.

Tackling inequity and promoting equality

The practice operates from a four storey building. Access to the main reception area, one consultation room and patient toilet (suitable for disabled people) is on ground level, with three treatments rooms and waiting area accessible by a few steps. Additional surgeries, waiting area and patient toilet, not accessible to patients who cannot negotiate stairs, are located on the upper first floor and second floor. There is on street parking available around the building.

The practice had access to translation services and in addition staff spoke eight different languages including Russian, Polish, Urdu, and Greek. The practice had a high number of patients whose first language was not English and they did not have any homeless or travellers registered.

There was a hearing loop to help those with hearing impairments, the practice were able to obtain information in other formats or languages if required.

Access to the service

The practice was open Monday to Friday 9am – 5.30pm and offered extended hours for both NHS and private patients. The late evening opening varied, there were posters in the waiting area advising patients of these, or they could request information from the receptionist. We noted on the day of the inspection the practice was open on three evenings until 7pm, this met the needs of patients unable to attend during the working day. The practice carried out domiciliary dentistry to patients who lived in local care homes.

Appointments could be booked by phone or in person. Staff told us patients were seen as soon as possible for emergency care and this was normally on the same day. Patients we spoke with and comment cards said that the practice had responded quickly when they had a need for urgent treatment.

The practice's answer phone message detailed how to access out of hours emergency care if needed and information was displayed on the outside of the building.

All the patients we spoke with were satisfied with the appointments system and said it was easy to use.

Concerns & complaints

The practice had a system in place for handling complaints and concerns from patients. We noted there was good information in the waiting area telling patients how they could raise a complaint. There was also information about the local advocacy groups such as the patient advice and liaison service. Further information was available in the practice's information leaflet which included detail of external agencies that could help if patients did not want to complain directly to the practice.

We spoke with two patients who had complained to the practice. One patient had left several answerphone messages but had not received a call back from the practice. The practice had recently had a new telephone system installed and through the patient feedback recognised that they were not accessing one of the voice mail boxes. This training issue was addressed with staff and a procedure put into place. The patient felt they had been listened to and the practice dealt with the complaint well.

Are services well-led?

Our findings

Governance arrangements

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, needle stick injury and safeguarding people. The practice completed the NHS information governance tool kit each year to measure its compliance with the laws regarding how patient information is handled.

There was no robust system for quality assurance within the practice; for example

- Poor maintenance of the building fabric, fixtures and fitting which potentially compromised the practices ability to comply with infection control standards. Although this was identified in the infection control audit of May 2015, mydentist had not agreed a date for the work to be started.
- Quality assurance checks of X-ray images were not robust.
- The replacement of chemicals within the X -ray developing machine was not always recorded.
- Spent waste material not collected since April 2015.
- Clinical waste bags not labelled.

There were meetings involving all the staff where ranges of practice issues were discussed such as administrative protocols, complaints, and targets. Minutes of the meetings were taken for those who could not attend. The mydentist group sent through regular bulletins which gave information on complaints, compliments, changes, and updates. The staff told us that they found these useful and they were able to share the information and learning in the practice.

Staff received a yearly appraisal of their performance, in which they were set specific objective which were then reviewed after six months. Staff reported that their appraisal was useful, and helped them identify any further training needs for example one staff member had been included as part of the domiciliary visiting team.

Staff reported they felt supported by the management team and enjoyed their work.

Leadership, openness and transparency

We found that there was a lack of clear clinical leadership to have oversight of the quality assurance in the practice. We spoke with the clinical support manager who attended the practice usually two weekly or sometimes more frequently, he told us that he undertook regular audits with the dentists. The results were discussed individually with the dentist concerned but the learning was not shared, the audits were not available in the practice for us to see.

The practice manager was responsible for the dental nurses and managed performance through appraisal and review system.

Staff told us they felt able to raise concerns at any time and did not wait for the monthly meeting, was aware of the whistle blowing policy, and understood when it was appropriate to use. Staff felt their suggestions were listened to for, example, following her fire warden training the staff member suggested and implemented changes to the evacuation drill to ensure that patients and staff would be kept safe.

Learning and improvement

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. Staff told us they had good access to training and the practice monitored it, to ensure essential training was completed each year.

There was no system of peer review in place for the dentists to help monitor their performance and drive improvement; however, staff we spoke to said that they met regularly to discuss cases and events. We reviewed minutes of a meeting held in October that recorded this would be formal meetings from November 2015.

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

Patients were given the opportunity to give feedback and influence how the service was run at each appointment. The practice offered comment cards for the NHS family and friends test as well as their own questionnaire. The practice had made changes following patient feedback, for example, a patient had told the practice that the letters they sent out did not have a date. The practice informed head office and the template was amended.

Although there was no specific survey for staff, staff told us that the manager and dentists were approachable and they

Are services well-led?

felt they could give their views about how things were done at the practice. Staff confirmed that they had regular meetings where they could suggest improvements to how the practice ran.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation: 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment 12(1)(2)(d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; • We found poor maintenance of the building fabric, fixtures, and fittings had potentially compromised the practice's ability to comply with infection prevention standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation: 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance 17 (1)(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; We found that the systems to monitor quality were not robust. • The assurance process for monitoring the quality of X-ray images was irregular and insufficient to reduce the risk of patients being subjected to further unnecessary X-rays. • Record keeping for changing of chemicals used in the X-ray developing machine was inconsistent.

This section is primarily information for the provider

Requirement notices

- Clinical waste bags were not labelled with the practice postcode.
- Spent waste chemicals had not been collected regularly.