Arkh-View Surgeries Limited

HB Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 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 not providing safe care in accordance with the relevant regulations

Are services effective?

We found that this practice was not 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

HB Dental is located in the London Borough of Bromley and provides mainly NHS and private dental services to patients. The demographics of the practice was mixed, serving patients from a range of social and ethnic backgrounds. The practice is open Monday to Fridays from 9.00am to 6.00pm, except Wednesdays when they open until 7.00pm. The practice facilities include three consultation rooms, a decontamination area and reception and waiting area. The premises are wheelchair accessible.

The staff structure comprises three dentists and four dental nurses, one receptionist and a practice manager.

The practice manager is the registered manager. At the time of our inspection the practice manager was away on extended leave. The appropriate notifications had been submitted to the CQC to report the absence. 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 inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

Thirty patients provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

Summary of findings

- There were effective processes in place to reduce and minimise the risk and spread of infection.
- There were appropriate equipment and access to emergency medicines to enable the practice to respond to medical emergencies. Staff knew where equipment was stored.
- All clinical staff were up to date with their continuing professional development.
- There was appropriate equipment for staff to undertake their duties, and equipment was maintained appropriately.
- Patients' needs were not always assessed and care was not always planned in line with current guidance.
- Governance arrangements in place were not effective to facilitate the smooth running of the service, and there was no evidence of audits being used for continuous improvements.
- There were not appropriate systems in place to safeguard patients
- Consent was not always obtained and recorded appropriately.

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

- Ensure the practice has an effective system to assess, monitor and mitigate the risks arising from undertaking of the regulated activities.
- Ensure that appropriate governance arrangements are in place for the safe running of the service by establishing systems to monitor and assess the quality of the service
- Ensure audits of various aspects of the service are undertaken at regular intervals to help improve the quality of service. Practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.

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 staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competency and ensure all staff are aware of their responsibilities as it relates to their role.
- Review processes in place for ensuring staff have required knowledge and understanding of safety incidents and know how and where to report them.
- Review currentprotocols and procedures to ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review practice's safeguarding protocols and staff training and ensure all staff are aware of their responsibilities.

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 not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

The practice undertook risk assessments and there were processes to ensure equipment and materials were maintained and safe to use. Dental instruments were decontaminated suitably. Medicines and equipment were available in the event of an emergency and stored appropriately.

The provider did not have systems in place to ensure people were safeguarded from abuse. Not all staff had received child protection and vulnerable adults training and some staff we spoke with did not demonstrate appropriate awareness of safeguarding issues. Systems were in place for the provider to receive safety alerts from external organisations however they were not fully appropriate as they did not ensure they were shared with staff. Processes were not in place for staff to learn from incidents and lessons learnt were not discussed amongst staff. The practice radiation protection file was not up to date.

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

There were not suitable systems in place to ensure patients' needs were assessed and care and treatment. Not all dentists were following published guidance, such as from the National Institute for Health and Care Excellence and The Department of Health. Staff told us they gave patients relevant information to assist them in making informed decisions however treatment plans did not evidence this.

The practice maintained dental care records however staff were not always documenting when they gave oral health advice, updated medical histories and whether patient details were updated. Information was available to patients relating to health promotion including smoking cessation and maintaining good oral health.

Staff did not have information available to confirm whether they were up to date with their continuing professional development requirements. Not all staff we spoke with were aware of their responsibilities under the Mental Capacity Act (MCA) 2005 or how it related to their role.

Are services caring?

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

Feedback from patients was positive. Patients indicated that staff were professional and caring and treated patients with dignity. We received feedback from 30 patients via Care Quality Commission comment cards. Patients were complimentary about staff, describing them as warm, accommodating and caring. Patients told us that staff acted in a professional manner and were helpful.

Patients commented that they found the practice clean and tidy and they did not have problems accessing the service.

Are services responsive to people's needs?

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

Summary of findings

Patients had access to the service which included information available via the practice website. There was a practice leaflet with relevant information for patients. Urgent on the day appointments were available during opening hours. In the event of a dental emergency outside of opening hours details of the '111' out of hours service were available for patients' reference.

There were systems in place for patients to make a complaint about the service if required. Information about how to make a complaint was readily available to patients.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

Governance arrangements were not in place for effective management of the practice. Staff meetings were held however they were not being used for learning and development. Leadership structures were unclear. The provider did not provide opportunities for staff for professional development. Audits were being completed but not used as a tool for continuous improvement and learning.

HB Dental Practice

Detailed findings

Background to this inspection

The inspection took place on the 14 October 2015 and was undertaken by a CQC inspector and a dental specialist adviser. Prior to the inspection we reviewed information submitted by the provider and information available on the provider's website and NHS Choices. We informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit we spoke with members of staff which included the dentists, dental nurses, trainee dental nurse, practice manager and receptionist. We reviewed policy documents, staff records and CQC comment cards completed by patients.

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

Systems were in place for safety and medical alerts to be received by the registered manager. This included alerts from NHS England and the Medicines and Healthcare products Regulatory Agency (MHRA). At the time of our inspection the registered manager was on extended leave and a colleague was covering their role. Arrangements had not been made for the acting practice manager to receive safety alerts whilst they were covering for their colleague. We discussed with the practice and they confirmed that the appropriate arrangements would be made to ensure this was rectified. We saw evidence of how alerts were disseminated amongst staff when the substantive practice manager was there; however this had not occurred since June 2015.

The practice had an incidents and accident reporting procedure. All incidents and accidents were reported in the incident and accident book. We reviewed the incidents and accidents log and there had been three accidents over the past 12 months. They had all been handled and reported appropriately. The acting practice manager told us that if relevant they were also discussed with staff during team meetings to share learning from the event. We reviewed the team meeting minutes for the past year and found that none of the reported incidents had been discussed. Most staff we spoke with, however were aware of reporting procedures including who and how to report an incident to.

There had not been any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013) incidents, within the past 12 months. The acting practice manager demonstrated limited understanding of RIDDOR regulations; however appropriate documentation was in place to record if they had an incident and they told us they would seek guidance from the manager at their head office if required.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for safeguarding adults and children protection. There was no appointed safeguarding lead at the time of our inspection. The acting practice manager was unaware that one was required. Staff in the practice did not have access to or know the details of the local authority safeguarding team to report suspected or actual cases of abuse. Whilst this information was not available to hand the acting practice manager demonstrated that they would be able to find out the information if required.

There were seven clinical members of staff and only one member was able to demonstrate completion of child protection and adult safeguarding training. Staff we spoke with demonstrated limited knowledge of safeguarding issues. The acting practice manager provided us with documentation to confirm that the rest of staff were due to complete training on the 26 October 2015.

The practice was following guidance from the British Endodontic Society relating to the use of rubber dam for root canal treatment. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway].

Patients were requested to complete medical history forms including existing medical conditions, social history and any medication they were taking. Medical histories were not always updated appropriately. Some records we reviewed had medical histories that were up to three years old. Patients had attended for appointments within this time but there was no record of medical history being updated.

Medical emergencies

The provider had appropriate arrangements to deal with medical emergencies. There were emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Staff also had access to emergency equipment on the premises including an automated external defibrillator (AED) in line with Resuscitation Council Guidance UK guidance and the General Dental Council (GDC) standards for the dental team. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. We saw records of the checks that were carried out to ensure the medicines were not past their expiry date. The practice had medical oxygen available. The medical emergencies medicines and equipment was stored in a

Are services safe?

locked cupboard which required staff to use a ladder to access it. We discussed this with the acting practice manager and they agreed to store it in a more central and accessible locations.

All clinical staff had completed basic life support training in July 2015 and this training was repeated annually.

Staff recruitment

There was a full complement of the staffing team. The team consisted of three dentists, three nurses, one trainee dental nurse, a practice manager and receptionist. We saw confirmation of all clinical staff's registration with the General Dental Council (GDC).

The practice had a recruitment policy and procedure that outlined how staff were recruited and the pre-employment checks that were carried out before someone could commence work in the practice. This included confirming professional registration details, proof of address, proof of identification and qualifications, references, indemnity, Disclosure and Barring Services (DBS) check, curriculum vitae and immunisation proof. We reviewed staff recruitment files and saw that most pre-employment checks were carried out except for the obtaining and recording of references from past employers for three staff and a DBS check for one clinical member. Following the inspection we were told that a DBS had now been applied for.

Monitoring health & safety and responding to risks

There were arrangements in place to respond to and deal with risks and foreseeable emergencies. This included having a business continuity plan in place. The plan covered events such as power failure, telephone failure and flooding in the premises. There were contact details of relevant organisations with telephone numbers of who to contact in the event of an emergency. Staff were aware of the plan and what to do in the event of an incident.

The provider carried out practice risk assessments. The risk assessment highlighted potential significant hazards and actions to mitigate the risks. The last risk assessment was carried out in August 2013. The acting practice manager told us that they planned to update it in the coming months.

Staff were unaware whether an up to date fire risk assessment had been carried out and were unable to find paperwork to confirm when the last one was completed.

Infection control

The practice had an infection control policy that outlined the procedure for all issues relating to minimising the risk and spread of infections. One of the dental nurses was the infection control lead.

There was a separate decontamination area. There were two sinks in the decontamination room; one for washing and one for rinsing dental instruments.

One of the dental nurses gave a demonstration of the decontamination process which was in line with guidance issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05). This included manually cleaning; inspecting under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required); placing in the autoclave; pouching and then date stamping, so expiry date was clear. Staff wore the correct personal protective equipment, such as apron and gloves during the process.

We reviewed records of the checks and tests that were carried out on the autoclaves. Staff were using the official manual that came with the autoclave to record the daily and weekly checks.

All relevant staff had been immunised against blood borne viruses and we saw evidence of this. There was a contract in place for the safe disposal of clinical waste, which was collected every two weeks. We saw the consignment notes of collections from September 2015. The practice had blood spillage and mercury spillage kits.

The surgeries were visibly clean and tidy. There were appropriate stocks of personal protective equipment for both staff and patients such as gloves, safety glasses and disposable aprons. There were enough cleaning materials for the practice. Cleaning equipment was stored appropriately. Wall mounted paper hand towels and hand gel was available as were clinical waste bins. The dental nurses cleaned all surfaces and the dental chair in the surgery in-between patients and at the beginning and end of each session of the practice in the mornings/ evenings.

The last legionella risk assessment had been completed in September 2015. Actions were identified and the practice was working towards implementing them. [Legionella is a

bacterium found in the environment which can contaminate water systems in buildings]. The dental lines were maintained with a purifying agent. Taps were flushed daily in line with recommendations.

Infection control audits were being carried out and we reviewed the most recent one carried out in April 2015.

Equipment and medicines

There were appropriate service arrangements in place to ensure equipment was maintained. There were service contracts in place for the maintenance of the autoclave and pressure vessel. The air compressor and pressure vessel had been inspected in August 2015 and certified as passed. The autoclave was serviced in December 2014 and next due in December 2016. The practice had portable appliances and carried out PAT (portable appliance testing) annually. Appliances were last tested 0n 6 October 2015.

Radiography (X-rays)

Staff told us they had completed radiology training; however only one dentist was able to evidence it through providing a certificate. The practice had an external radiation protection adviser (RPA); however staff were unsure who the radiation protection supervisor within the practice was. We reviewed the radiation protection file and saw that the owner of the practice was the named RPS in the file. We discussed this with the owner and they were unaware that they held this position.

Radiographic audits were not being completed. We discussed this with the acting practice manager and other staff and no one was aware of the requirement to carry out audits.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients' needs were assessed, however we did not see evidence that care and treatment was always delivered in line with current legislation such as National Institute for Health and Care Excellence (NICE) guidance. For example, in the dental care records we checked, we did not see evidence of comprehensive assessments and treatment plans completed. Medical histories were not always updated; X-ray justifications and treatment options were not always recorded. Clinical notes did not record that a full assessment of the patient had been undertaken in line with record keeping guidelines such as those from the Faculty of General Dental Practice (FGDP).

Health promotion & prevention

There was some oral health and prevention information available to patients in the waiting area. Staff told us that oral health information was given to patients during consultations. They told us that they gave advice about maintaining better oral health including proper tooth brushing techniques and smoking cessation. We reviewed dental care records to confirm our findings and saw that this was not always documented.

Staffing

We reviewed staff training records and saw evidence that staff had attended life support training. We saw evidence that one clinical member of staff was up to date with their continuing professional development (CPD) however this information was unavailable for all other staff. [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 every five years]. Some staff we spoke with told us that they were up to date with their CPD but kept their certificates at home. We discussed this with the acting practice manager and they told us that staff usually took responsibility for their own training needs. There were no processes in place in the practice to check whether staff were up to date with their CPD. We gave the practice an opportunity to submit details of staff CPD following the inspection but they did not submit any documents.

We saw limited evidence for staff to pursue development opportunities within the practice.

Working with other services

The practice had procedures in place for referring patients. This included referring to the community dental services and local hospitals. One of the dentists explained that they had standard referral forms. The forms were completed by dentists and given to reception staff to process. Details of the referral were recorded in the patients' notes and a copy of the referral put on file. Reception staff were responsible monitoring responses. We reviewed some of the recent referrals made and saw they were completed appropriately.

Consent to care and treatment

Staff told us that informed consent for treatment was obtained verbally, recorded in the patients' notes and patients were given a treatment plan. We checked dental care records and saw that consent was not always documented appropriately. Treatment plans we reviewed were not completed by the dentists in that they did not complete the records to indicate where the problem was, diagnosis was not recorded and treatment options were not documented. Despite this, patients were being asked to sign to give consent.

Most staff whom we spoke with including clinical staff did not have an understanding of the requirements of the Mental Capacity Act (MCA) 2005, including the best interest principle and Gillick competency and had not received any training. [The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them]. Staff were unable to give examples of when the Act would apply or how it related to them in their role.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 30 patients through completed CQC comment cards. Feedback was positive and staff were described as helpful and caring. Patients said staff maintained their privacy during consultations and made them feel comfortable during treatment. Patient feedback indicated that staff were always respectful when speaking to patients.

We observed staff interaction with patients in the waiting room and saw that staff interacted with patients in a respectful and friendly manner. We saw that consultations were in private with the door closed and that staff never interrupted consultations unnecessarily. Conversations could not be overheard whilst patients were being treated and staff knocked on the treatment door if they needed to interrupt a consultation. The environment of the surgeries was conducive to maintaining privacy.

The reception and patient waiting area was very small; however we saw that reception staff made every effort to ensure they spoke to patients in lowered voices to maintain privacy.

Patients' information was held securely electronically. All computers were password protected with individual login requirements.

Involvement in decisions about care and treatment

Patient feedback indicated that they felt involved and informed in decisions about their treatment and care. They stated that suitable information was given and anything they did not understand was always explained.

Staff we spoke with told us they always explained the diagnoses to patients. Dentists used visual aids such as models to make their explanations clearer. The dental care records we checked however, did not demonstrate that patients were always involved in planning because it was not always documented in their clinical notes. For example, risks and benefits of treatment were not always documented and treatment plans were not completed showing that patients had been involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was open from 9.00am to 6.00pm Monday to Friday, except for Wednesdays when they opened until 7.00pm. Staff told us that the appointment times were reflective of patients' needs.

To respond effectively to patients' needs the practice had made various adjustments to the practice including ensuring leaflets were available in other formats such as large print and planning appointments outside of school times for parents as well at their children.

Patients experiencing pain and in need of an urgent appointment were always offered an appointment on the same day. If a patient had an emergency they were asked to come in, and would be seen as soon as possible.

Tackling inequity and promoting equality

The acting practice manager described the patient population as being evenly mixed in terms of ethnicity, gender and social background. The acting practice manager told us that they took account of the varying needs of patients and made reasonable adjustments to ensure all patients had equal access to the service. This included providing information in other languages if required.

The practice was set out over one level. There was step free access into the building and the building was suitable for wheelchairs and pushchairs to be manoeuvred around. The patient toilet was not wheelchair accessible and staff told us this was due to space restrictions on the premises.

The staff team was multi lingual with staff fluent in languages including French, Greek and Lithuanian. In the event of a patient needing translations in another language staff could access the NHS translation service.

The workforce was all female. The practice had arrangements in place with a practice close by that they could refer patients to if they wanted to be seen by a male dentist.

Access to the service

The practice had a website with information about their services, treatments, opening times and contact details. Opening times were displayed on the website and practice information sheet. The information sheet also had detailed information for patients outlining treatments and costs.

If patients required an appointment outside of normal opening times the practice provided patients with information about where they could go for treatment. This included the NHS "111" service and the local out of hours' service. The details of the service were on the practice answer machine message and contact numbers also displayed on their website.

Feedback received from patients did not highlight any issues with access to the service.

Concerns & complaints

The provider had a complaints handling policy that outlined how complaints were handled. If patients wanted to make a compliant staff would direct them to their policy which outlined how to complain and how their complaint would be handled.

At the time of our visit there had been eight complaints in the past 12 months. The complaints related to a range of issues including staff communication and treatment related. We reviewed the complaints and saw they had been handled in line with the policy. The patients affected had been written to with an explanation of how their complaint had been dealt with.

Are services well-led?

Our findings

Governance arrangements

Staff we spoke with told us they felt supported; however some staff were unclear about their roles, and we noted that responsibilities and lines of accountability were unclear. For example, the practice manager was acting in the role however they had not received a formal induction and was unclear about their areas of responsibility. There were no staff appointed for lead roles such as safeguarding and the member of staff appointed as the radiation protection supervisor did not know they had this role. Staff did not know who to go to in the event of needing advice or information.

There were a range of policies and procedures in place for the smooth running of the practice. This included policies for staff recruitment and human resources, infection control, training and health and safety. Policies were available in hard copy of via the computer and staff we spoke with were aware of this.

Clinical audits carried out included hand hygiene, medical history and clinical governance. We reviewed the audits and found that they were not being used to identify safety or quality issues in the practice. For example the audit on medical histories identified areas that required improvements; however there was no analysis to identify how this could be improved and no action plan put in place for improvement. We discussed the lack of analysis and follow up from audits with the acting practice manager. They were unaware that this was an area they needed to lead and said that information relating to audits was not an area that had been handed over to them as part of their remit.

Leadership, openness and transparency

Leadership in the practice was unclear. The acting practice manager was unsure about their responsibilities and what roles they had in the absence of the registered manager. The owner of the practice (who was also the nominated individual) was disconnected from the practice and did not demonstrate how they offered support to staff in the practice. Staff were complimentary about the acting practice manager and the support received. However it was unclear how the acting practice manager was supported and leadership structures upwards were not clear.

Staff we spoke with on the day of the inspection did not know what the duty of candour was and the expectations of them associated with it. Staff were unable to give any examples of when it would be applicable. [Duty of candour is a requirement on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

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Learning and improvement

The practice did not have any systems in place to support the communication about the quality of the service or monitor and encourage improvements. Team meetings were held monthly however they were not being used to discuss incidents or discuss learning. For example there had been eight complaints and three incidents over the past 12 months and none were discussed during team meetings. The practice did not demonstrate how they had shared learning or improved the service as a result of them.

Staff were not receiving formal supervision and there were no processes in place for staff to receive annual appraisals. Staff we spoke with did not demonstrate an understanding of the purpose of appraisals as a development tool.

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

The acting practice manager told us they carried out on-going patient satisfaction surveys and collected the NHS Friend and Family Test to obtain feedback about the service. At the time of our visit they had not analysed the results of any of the surveys and were unable to demonstrate how they acted on feedback from patients.

Staff we spoke with told us that they felt their views were sought and taken into account in service development, although they were unable to give us specific examples of where they had provided feedback.

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider was not ensuring that care and treatment was being provided with the informed consent of patients. Treatment plans were not filled in and patients were still signing them without confirmation of costs or treatment details. Staff did not demonstrate awareness or understanding of the Mental Capacity Act 2005 and did not know who it would apply to. Regulation 11 (1)

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 How the regulation was not being met: There was lack of effective processes in place for safety alerts to be shared and there was no learning or analysis from incidents. Risk assessment were not being carried out routinely, including a fire risk assessment and recent premises risk assessment Regulation 12 (1)(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

There was no appointed safeguarding lead. Not all staff had completed safeguarding training and did not display the required competencies or experience of safeguarding, including being able to identify abuse, knowing what action to take for an actual or suspected case, knowing the local authority procedures of how to report to them.

Regulation 13 (1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were limited systems in place to monitor or assess the quality of the service. The audits completed did not demonstrate continuous learning, patients records were not an accurate record of decisions take in relation to care and treatment, there were no formal processes in place to gain staff feedback and practice meetings were not being used for staff development or learning opportunities. There were no defined governance structures in place in the practice. Leads were not clearly defined. Regulation 17 (1), (2) (a), (b), (c), (e), (f).