Mr. Kayvan Khosravani

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 06 April 2016 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.

Background

Mr Kayvan Khosravani is a dental surgery located in the London Borough of Brent and provides both NHS and private dental treatment to both adults and children. The premises are on the ground floor and consist of three treatment rooms, an X-ray room, a reception area and a dedicated decontamination room. The practice is open on Monday - Friday 9:00am – 6:00pm.

The staff consists of the principal dentist, three dental nurses and the receptionist.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

We reviewed five CQC comment cards. Patients were positive about the service. They were complimentary about the friendly and caring attitude of the staff.

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

Our key findings were:

- There were appropriate equipment and access to emergency drugs to enable the practice to respond to medical emergencies. Staff knew where equipment was stored.
- Patients had good access to appointments including emergency appointments.

Summary of findings

- We observed staff to be caring, friendly, reassuring and welcoming to patients.
- Patients indicated that they found the team to be efficient, professional, caring and reassuring.
- Not all staff were up to date with their training to safeguard patients and were not aware of procedures to follow in case of raising a safeguarding concern.
- There was a lack of effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations.
- Staff did not receive appropriate support and appraisal as is necessary to enable them to carry out their duties.
- There was a lack of an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- 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.

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

- Ensure that the practice has and implements, robust procedures and processes that make sure that people are protected.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff.
- Ensure audits of various aspects of the service, such as radiography, infection control and dental care records are undertaken at regular intervals to help improve the quality of service. The practice should also check , that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure the practice establishes an effective system to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health

Summary of findings

giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.

- Review the storage of dental care records to ensure they are stored securely.
- Review the storage of records related to people employed and the management of regulated activities giving due regard to current legislation and guidance.

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 had an incidents and accident reporting procedure. All staff we spoke with were aware of reporting procedures including recording them on the accident form.

The practice did not have adequate systems in place for the management of substances hazardous to health. The practice did not have procedures in place for safeguarding adults and child protection. Details of the practice safeguarding lead, local authority safeguarding teams and other useful telephone numbers were not known to staff. The practice did not have a fire safety policy and an evacuation procedure. There was no recruitment or induction policy. The practice had not undertaken risk assessments to mitigate the risks relating to the health, safety and welfare of patients and staff.

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).

The practice assessed patients' needs and delivering care and treatment; in line with relevant guidance. The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the Faculty of General Dental Practice (FGDP) and the General Dental Council (GDC). Staff explained treatment options to patients to ensure they could make informed decisions about any treatment.

The practice did not have an induction programme. Not all staff were up-to-date with their recommended training.

Are services caring?

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

We reviewed five CQC comment cards. Patients were positive about the care they received from the practice. Patients commented they were treated with dignity and respect, were made comfortable and reassured. Patients told us they were treated in a professional manner and staff were very helpful.

We noted that patients were treated with respect and dignity during interactions at the reception desk and over the telephone. We observed that patient confidentiality was maintained.

Are services responsive to people's needs?

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

Patients had access to information about the service. Patients had good access to appointments, including emergency appointments. In the event of a dental emergency outside of normal opening hours patients were able to contact the practice and would be offered an appointment on the same day.

The practice provided friendly and personalised dental care. The practice had assessed the needs of patients with disabilities.

Summary of findings

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 Enforcement Action at the end of this report).

Policies and procedures were not effective to ensure the smooth running of the service. Most policies were generic and had not been considered in the context in which services were provided.

We noted that the practice did not have robust systems in place to identify and manage risks. Practice meetings were not being used to update staff or support staff.

There were no processes in place for staff development, no appraisals and no evidence of how staff were supported.

Audits such as those on infection control, the suitability of X-rays and dental care records, had been undertaken in the last 12 months. However, the audits were not completed appropriately including documented learning points so the resulting improvements could be demonstrated.

There were no mechanisms in place for obtaining and monitoring feedback for continuous improvements.

Mr. Kayvan Khosravani

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.

We carried out an announced, comprehensive inspection on 06 April 2016. The inspection was carried out by a CQC inspector and a dental specialist advisor. Prior to the inspection we reviewed information submitted by the provider.

During our inspection visit, we reviewed policy documents and staff records. We spoke with the principal dentist, one dental nurse and the receptionist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We reviewed the practice's decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

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 had an incidents and accident reporting procedure. All staff we spoke with were aware of reporting procedures including recording them on the accident form. There was no reported incident within the last 12 months.

The practice did not have a policy in place for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Staff we spoke with did not understand the requirements of RIDDOR. The practice had limited risk assessments around the safe use, handling and Control of Substances Hazardous to Health, 2002 Regulations (COSHH). Staff we spoke with did not understand the requirements of COSHH. When asked, staff could not provide a RIDDOR policy or a COSHH folder.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place for safeguarding adults and child protection. The policy contained details of the local authority safeguarding teams, whom to contact in the event of any concerns and the team's contact details. All members of staff we spoke with were able to give us examples of the type of safeguarding incidents and concerns that would be reported. However, not all staff were aware of the procedure to be followed. There were no reported safeguarding incidents in the last 12 months.

We saw evidence that only two clinical staff members had completed child protection and safeguarding adults training to an appropriate level. No records were available for other members of staff.

The practice did not have a health and safety policy. The practice had not undertaken risk assessments with a view to keeping staff and patients safe.

The practice was not following guidelines issued by the British Endodontic Society in the use of rubber dams (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. Rubber dams should be used when endodontic treatment is being provided. On the occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had emergency resuscitation equipment such as oxygen and manual breathing aids. The practice did not have an automated external defibrillator (AED) in line with the Resuscitation Council UK guidelines. (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). Emergency medicines such as Salbutamol and Midazolam were not available. The practice ordered these emergency medicines on the day of the inspection.

All staff were aware of where medical equipment was kept and knew how to respond if a person suddenly became unwell. We saw evidence that four members of staff had completed training in emergency resuscitation and basic life support. No records were available for other staff. The principal dentist told us training would be arranged to take place at the practice for all members of staff.

Staff recruitment

The practice did not have a recruitment policy. We reviewed the recruitment files for all members of staff. The records did not contain all evidence required to satisfy the requirements of relevant legislation. There was evidence that all staff had the necessary immunisation and evidence of professional registration with the General Dental Council (where required).

There were no records which showed that references were obtained, identity checks and eligibility to work in the United Kingdom, where required, were carried out for members of staff. The practice had undertaken Disclosure and Barring Service (DBS) checks for one relevant members of staff; there were no records available for other staff members. [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]. When asked the practice was not able to provide evidence that these checks had been carried out.

Monitoring health & safety and responding to risks

Are services safe?

The practice did not have a health and safety policy that outlined staff responsibilities towards health and safety and accidents. The practice had not carried a premises risk assessments. The practice did not have arrangements in place to deal with foreseeable emergencies.

The practice had undertaken a fire risk assessment in March 2016 and a fire action plan was recommended. We saw records which showed that fire safety signs would be installed on 13 April 2016. Fire extinguishers were present.

The practice had a policy on safety alerts which list the agencies that provide alerts and how they should be dealt with. The principal dentist told us the practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. At the time of our inspection we did not see records which showed that the practice received and responded to patient safety alerts, recalls and rapid response reports issued from the MHRA and other relevant external agencies. When asked the practice did not provide evidence of this.

Infection control

There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, waste management and immunisation.

We examined the facilities for cleaning and decontaminating dental instruments. The practice had a dedicated decontamination room. A dental nurse showed us how instruments were decontaminated. They wore appropriate personal protective equipment including heavy duty gloves while instruments were decontaminated. Instruments were cleaned prior to being placed in an autoclave (sterilising machine).

We saw instruments were placed in pouches following sterilisation. However, we observed pouches were open and undated. We found daily, weekly and monthly tests were performed to check the steriliser was working efficiently and a log was kept of the results. We saw evidence the parameters (temperature and pressure) were regularly checked to ensure equipment was working efficiently in between service checks.

The practice had an ultrasonic bath which had not been serviced and no validation checks such as the foil test or protein residue test had been carried out. Staff were not aware of these requirements.

We observed how waste items were disposed of and stored. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated and stored at the practice. This included clinical waste and safe disposal of sharps. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of which was in line with guidance.

Hand washing posters were displayed next to each dedicated hand wash sink to ensure effective decontamination of hands. Patients were given a protective bib and safety glasses to wear when they were receiving treatment. There were good supplies of protective equipment for patients and staff members. The practice had carried out a risk assessment following the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The practice had undertaken a Legionella risk assessment in December 2015. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). We did not see records which showed that the water temperatures were being monitored. We noted that following the risk assessment an action plan was recommended. When asked staff had not completed the action plan and were not aware of it.

We noted an infection control audit had been carried out by the Brent Local Area Team on 31 March 2016. The recommendations included having a documented procedure for the manual cleaning of instruments and ensuring cleaning equipment is colour coded and appropriately stored.

Equipment and medicines

The practice had service arrangements in place for some of the equipment to ensure it was well maintained. The autoclave had been serviced in October 2015. We did not see records of a pressure vessel check. When asked staff were unsure if a pressure vessel check had been carried out. The practice had portable appliances and had carried out portable appliance tests (PAT) in April 2016.

Radiography (X-rays)

The practice did not have a well maintained radiation protection file. We checked the provider's radiation protection records as X-rays were taken and developed at the practice. We also looked at X-ray equipment and talked with staff about its use.

Are services safe?

The practice did not have local rules. The principal dentist told us the practice had a radiation protection adviser (RPA). However, we did not see records of a contract with the RPA. The practice did not have an appointed radiation protection supervisor (RPS). The practice had not completed a Health and Safety Executive (HSE) notification to inform the HSE of X-ray equipment at the premises. The radiation protection file did not contain a critical examination and acceptance test report following installation of the X-ray equipment. We were shown records for the assembly of X-ray equipment dated January 2013. Following our inspection the principal dentist sent us confirmation of the critical examination and acceptance test report was booked for 18 April 2016.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients' needs were assessed and care and treatment was delivered in line with current guidance. This included following the Faculty of General Dental Practice (FGDP) and General Dental Council (GDC) guidance. The principal dentist told us they regularly assessed each patient's gum health and took X-rays at appropriate intervals. This could be improved by giving due regard to guidance from National Institute for Health and Care Excellence (NICE) and guidance and Delivering Better Oral Health toolkit. 'Delivering better oral health' is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

During the course of our inspection we checked dental care records to confirm our findings. We saw evidence of assessments to establish individual patient needs. The assessments included completing a medical history, outlining medical conditions and allergies and a social history. An assessment of the periodontal tissue was taken and recorded using the basic periodontal examination (BPE) tool. [The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums]. We saw records which showed X-rays were justified, graded and reported on.

Health promotion & prevention

Staff told us appropriate information was given to patients for health promotion. However, there was no information available at the practice for health promotion. When asked staff were not able to provide examples of health information given to patients such as diet advice and smoking cessation. We checked dental care records which did not show health promotion information was given to patients.

Staffing

The practice did not have an induction programme for staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients.

We reviewed the training records for all members of staff. Opportunities existed for staff to pursue continuing professional development (CPD). There was evidence to show that some members of staff were up to date with CPD and registration requirements issued by the General Dental Council. Staff had completed training in infection control, radiography, oral cancer and fire safety. Records of CPD for one member of staff were not available.

There was no formal appraisal system in place to identify training and development needs.

Working with other services

The practice did not have arrangements in place for working with other health professionals to ensure quality of care for their patients. We asked the principal dentist about the practice policy for referring patients to other practices or specialists if the treatment required was not provided by the practice. The principal dentist told us no patients had been referred in the last two years and no referral protocol was in place.

Consent to care and treatment

The practice ensured valid consent was obtained for care and treatment. Staff confirmed that individual treatment options, risks and benefits and costs were discussed with each patient who then received a detailed treatment plan and estimate of costs. Patients would be given time to consider the information given before making a decision. The practice asked patients to sign treatment plans and a copy was kept in the patients dental care records. We checked dental care records which showed treatment plans signed by the patient. The dental care records showed that options, risks and benefits of the treatment were discussed with patients.

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 themselves. Staff we spoke with had not received MCA training and did not demonstrate an awareness of their responsibilities under the Act. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed five CQC comment cards completed by patients in the two weeks prior to our inspection. Patients were complimentary of the care, treatment and professionalism of the staff and gave a positive view of the service. Patients commented that the team were courteous, friendly and kind. Patients commented that they were treated with dignity and respect**.**

Staff explained how they ensured information about patients using the service was kept confidential. They told us patients were able to have confidential discussions about their care and treatment in a treatment room. We noted that dental care records were stored in cupboards in the reception area. Improvements could be made to ensure that the records could be securely locked.

Staff told us that consultations were in private and that staff never interrupted consultations unnecessarily. We observed that this happened with treatment room doors being closed so that the conversations could not be overheard whilst patients were being treated. The environment of the treatment rooms was conducive to maintaining privacy.

Involvement in decisions about care and treatment

The principal dentist told us they used a number of different methods including tooth models, display charts, pictures, and X-rays. A treatment plan was developed following discussion of the options, risk and benefits of the proposed treatment.

Staff told us the dentists took time to explain care and treatment to individual patients clearly and were always happy to answer any questions. Patients told us that treatment was discussed with them in a way that they could understand.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We viewed the appointment book and saw that there was enough time scheduled to assess and undertake patients' care and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

There were effective systems in place to ensure the equipment and materials needed were in stock or received well in advance of the patient's appointment. These included checks for laboratory work such as crowns and dentures which ensured delays in treatment were avoided.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. The practice had access to interpretation services.

The practice was located on the ground floor of the premises and recognised the needs of different groups in the planning of its service. The practice was accessible to people using wheelchairs, or those with limited mobility, which included a ramp, low reception counter in the reception area and a disabled toilet.

Access to the service

The practice had arrangements for patients to be given an appointment outside of normal working hours. We asked staff how patients were able to access care in an emergency. They told us that patients were seen on the same day if an emergency appointment was required. Staff told us out of hour's contact details were not given on the practice answer machine message when the practice was closed. Staff told us an emergency message would be placed on the answer machine on the day of the inspection. Emergency out of hour's information was displayed on the door of the practice.

Feedback received from patients indicated that they were happy with the access arrangements. Patients said that it was easy to make an appointment.

Concerns & complaints

The practice had a policy to manage patient complaints. Improvements could be made to ensure the policy included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. Information about how to make a complaint was not readily available to patients.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place to ensure a timely response. The practice had not received any complaints in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

There was no evidence that adequate governance arrangements were in place at the practice. Most policies were generic and had not been considered in the context in which services were provided. The practice did not have arrangements for identifying, recording and managing risks through the use of risk assessments, audits, and monitoring tools. The practice did not have a COSHH folder and limited risk assessments had been done around the safe use and handling of COSHH products. The practice had not undertaken health and safety risk assessments.

The practice had not identified various risks such as those arising from employing staff without the necessary pre-employment checks such as DBS checks and obtaining references We found that practice policies were generic, not tailored to the practice and referred to staff that were not employed at the practice.

The practice had staff meetings to discuss clinical governance issues such as fire safety, CPD, complaints and Legionella. The principal dentist told us there were also informal discussions on a regular basis.

Leadership, openness and transparency

The principal dentist had responsibility for the day to day running of the practice and worked at the practice part time. Responsibilities to undertake key aspects of service delivery had not been suitably delegated.

Learning and improvement

We found that the practice did not have a formalised system of learning and improvement. There was no schedule of audits at the practice. The practice had completed an infection control audit in July 2015 and there was no action plan in place. The receptionist was the infection control lead and did not understand the requirement to complete infection control audits on a regular basis. We noted Brent Local Area Team completed an infection control audit on 31 March 2016.

An X-ray audit had not been undertaken at the practice. The principal dentist told us that practice would develop a schedule of audits in future.

We found that there was a centralised monitoring of professional development in the practice. There was no programme of induction for staff. There had been no recent staff appraisals to support staff in carrying out their role. Staff told us they had not completed an appraisal in the last 12 months.

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

The practice did not have any systems in place for seeking or acting on feedback from patients, staff or the public.

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 **How the regulation was not being met:** **The provider had not assessed the risk of preventing, detecting and controlling the spread of infections.** **Regulation 12(1) (2) (h)**

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:** • Not all staff had received safeguarding training that was relevant to their role • Staff were not aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. **Regulation 13(1) (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical 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

- Staff did not receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.

Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **The provider did not have effective systems in place to :** • Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity • 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. • Ensure that their audit and governance systems remain effective. • Maintain securely an accurate and complete record relating to people employed and the management of regulated activities. **Regulation 17 (1) (2) (a) (b) (d) (f)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** • The provider did not have an appropriate process for assessing whether an applicant is of good character and to assess their qualifications.

This section is primarily information for the provider

Enforcement actions

- The provider did not have an appropriate process for assessing and checking that people have the competence, skills and experience required to undertake the role.

- The provider did not have an effective recruitment procedure in place to assess the suitability of staff for their role. Not all the specified information (Schedule 3) relating to persons employed at the practice was obtained.

Regulation 19 (1) (a) (b) (2) (a) (3)