Smile Care Twyford Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 March 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 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

Smile Care Twyford (also known as Berkshire Dental Care) is located in converted premises in the centre of Twyford. There are four dental treatment rooms at the practice and all are on the ground floor. The practice is part of a group of practices. There are four dentists, a foundation dentist (a foundation dentist is a qualified dentist undertaking a year of practice under supervision), a dental hygienist, a part time dental nurse, four trainee dental nurses, a practice manager and a receptionist.

The practice is open from 9am every morning. It closes at 6pm on a Monday, 5.30pm from Tuesday to Thursday and at 5pm on a Friday.

The practice was in the process of changing their registered manager. At the time of inspection CQC had received notifications of the departure of the previous manager and the pending application of the new manager. We noted that the incoming manager had applied for, and was awaiting, their Disclosure and Barring Service (DBS) check. (A DBS check identifies 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). A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Eleven patients gave us feedback about the service. There were six completed comment cards and we spoke with five patients in person. All were positive about the service they received particularly focussing on the dentists being caring and giving them information upon which to make decisions about their care. Patients also said they were not rushed and had sufficient time for their examinations and treatments.

The inspection found the practice had breached Regulation 17, Good Governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not carried out mandatory X-ray and infection control audits and did not have appropriate arrangements in place to ensure emergency equipment was in working order. We have issued a requirement notice asking the provider to take action to address these risks.

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

Our key findings were:

- Staff had been trained to handle emergencies.
- Patients' needs were assessed and care was planned and delivered in line with general professional and other published guidance.
- The practice was visibly clean and well maintained.
- Staff received training relevant to their roles and were supported in their continuing professional development.
- Appropriate arrangements were mostly in place to protect patients from the risks posed by exposure to X-rays. However, the practice could not demonstrate that they had undertaken an audit of the quality of X-rays taken.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained. However the practice had not completed adequate checks of the automated external defibrillator and medical oxygen.
- The provider held emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Governance arrangements were in place for the smooth running of the practice; however the practice did not have a structured plan in place to audit quality and safety including the mandatory audits for infection control and radiography. They planned to establish a more detailed system for this.

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

- Undertake mandatory audits including an audit of the infection control measures in place and the suitability of the environment in reducing risks of cross infection. It must also undertake audits of the outcome of X-rays. The practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure staff that check the emergency equipment are appropriately trained to identify whether the equipment is in working order and fit for use.

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

- Gain access to NHS Choices website and respond to patient comments lodged there.
- Undertake fire evacuation drills.

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.

However, the practice did not have robust systems in place for auditing infection control and dental radiography (X-rays). The quality of X-rays had not been subject to audit and infection control audits were not completed as required by current guidance.

There were, however, appropriate arrangements in place for clinical waste control and management of medical emergencies at the practice. We found that most equipment used in the dental practice was well maintained although the practice had to replace their medical oxygen and defibrillator within 48 hours of the inspection due to the issues highlighted during the inspection.

The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. There was a strong focus on oral health and prevention of dental health problems. The practice used current national professional guidance to guide their practice.

The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

Are services caring?

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

Our observations of the practice showed staff to be kind and compassionate in their dealings with patients.

We received six CQC comment cards and spoke with five patients during the visit. All of the patients commented on the quality of care they received.

Patients had completed returns for the friends and family recommendation test. We saw 60 completed returns in a seven month period and all the patients said they were either very likely or likely to recommend the practice to others.

Are services responsive to people's needs?

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

The practice was aware of the needs of the population it served. Extended opening hours were available to patients who found it difficult to attend for appointments during the customary working day.

Patients could access treatment and urgent care when required. The practice provided patients with written information about how to prevent dental problems.

All of the dental treatment rooms were on the ground floor enabling ease of access for patients with mobility difficulties and families with prams and pushchairs.

Summary of findings

Are services well-led?

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

The dentists were visible in the practice and staff told us they were approachable. Staff were supported with appropriate training and appraisal.

There had been a change in both company and local management during the last six months and we saw an open management style and all staff felt able to contribute to the running of the practice.

However, management within the practice had failed to identify that mandatory audits of the quality of X-rays had not been completed. They had also failed to identify that recording of audits of control of infection had not been undertaken at required intervals.

The member of staff assigned to check emergency equipment had not been adequately trained to undertake the checks.

Smile Care Twyford Limited

Detailed findings

Background to this inspection

The inspection was undertaken by a CQC lead inspector and a dental specialist advisor.

We informed NHS England area team that we were inspecting the practice. We did not receive any information of concern.

During the inspection we:

- Spoke with two dentists, the dental nurse, a trainee dental nurse and a member of the reception staff.
- Spoke with five patients.
- Undertook a review of records relevant to the management of the service.
- Ensured the specialist dental adviser looked at a number of anonymised patient records to corroborate that the dentist carried out their consultations, assessments and treatment in line with general professional guidelines.
- Carried out observations around 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 had a system in place for the reporting and recording of significant events, incidents and near misses. The provider had updated this system within the last six months and we were told that a new recording form had been introduced in January 2016. We noted that there had not been any incidents reported during the last two years. Staff we spoke with told us they would not hesitate to report any patient safety incidents.We were told that if an incident was reported it would be investigated and that learning from the incident would be shared via staff meetings to ensure that all staff were aware of the measures that should be taken to avoid a recurrence in the future. The new system also required incidents to be reported to the provider to enable learning from incidents to be shared across the group of practices.

The provider and the new practice manager told us if there was an incident or accident that affected a patient, they would give an apology and inform them of any actions taken to prevent a reoccurrence.

The area manager took responsibility for receipt and action arising from national patient safety and medicines alerts received by the practice. They ensured appropriate action was taken at practice level and records of the action taken were held at the practice.

Reliable safety systems and processes (including safeguarding)

We spoke with a number of staff during the inspection including two dentists, the dental nurse, a dental nurse in training, the practice manager and the receptionist. All the staff we spoke with were able to describe the types of abuse they might witness or suspect during the course of their duties. Staff records showed us that appropriate training in safeguarding both children and vulnerable adults had been undertaken by all staff. The practice had a safeguarding protocol in place and one of the dentists was the safeguarding lead for the practice.

Details of the local safeguarding agencies were held in hard copy. Staff we spoke with knew where to find the protocol and the safeguarding authority contact details and told us they would report any safeguarding concerns in line with the protocol.

Our discussions with dentists and practice staff, and review of dental care records showed that the dentists used a rubber dam during root canal work in accordance with guidelines issued by the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. The dentists we spoke with told us that in some cases patients refused the use of the rubber dam. In these cases the patient's decision was recorded in the dental records.

Staff were able to describe the action they would take if they suffered a needlestick injury. The dentists took personal responsibility for resheathing needles used to deliver anaesthetic.

Medical emergencies

The practice had an automated external defibrillator (AED). [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 checked this during the inspection and found that both child and adult pads were available and were in date. However, the AED was not charging properly and was not fit for use at the time of our inspection. Medical oxygen was held at the practice. However, the cylinder was nearly empty when we checked it. Both the AED and medical oxygen were checked on a regular basis but the member of staff undertaking the check had not received appropriate instructions on what to look for to ensure the equipment was safe. We discussed our findings with both the area manager and practice manager. They sent us photographic evidence within two working days to show that a replacement full oxygen cylinder had been received and a new defibrillator purchased. Both were held with the emergency medicines at the practice.

The practice held emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. One of the dental nurses was responsible for checking emergency medicines. We saw records to show that the medicines were checked monthly. All medicines were within their expiry date.

Staff recruitment

We reviewed the staff recruitment files of seven staff and found that appropriate pre-employment recruitment checks had been undertaken for qualified clinical staff and administration staff. For example, proof of identity,

Are services safe?

references and application forms were retained. The practice demonstrated that dentists, the dental nurse and trainee dental nurses had completed Disclosure and Barring Service (DBS) checks.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. There were a number of risk assessments that had been completed. For example, Control of Substances Hazardous to Health. Other assessments included fire safety, radiation, general health and safety issues affecting a dental practice and water quality risk assessments. However, the practice had not implemented all of the recommendations from the fire assessment because fire drills were not undertaken.

We also found clinical staff were immunised against the blood borne virus Hepatitis B that could be transmitted from patients because of a contaminated sharps injury.

Infection control

The practice was clean and tidy. Dental surgery rooms were clutter free and the system for disposal of clinical waste from these rooms, including sharps bins, was appropriate. We observed the decontamination process and noted suitable containers were used to transport dirty and clean colour coded instruments between the treatment rooms and decontamination room. The practice used a system of manual scrubbing and an ultra-sonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier the instruments were then placed into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. All recommended tests utilised as part of the validation of the ultrasonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log book and demonstrated the effective working of this piece of equipment

However, audits of the processes and procedures to reduce the risk of cross infection had not been undertaken since 2013. These were required to be undertaken every six months in accordance with current guidance. We therefore, could not identify whether the practice had found any areas for improvement or that action plans to reduce the risk of cross infection were in place.

The practice had a legionella risk assessment in place. **(**Legionella is a term for particular bacteria which can contaminate water systems in buildings). Actions required from the risk assessment had been completed and control measures were undertaken.

The practice had personal protective equipment (PPE) such as disposable gloves, aprons and eye protection available for staff and patient use. The treatment rooms had designated hand wash basins for hand hygiene and liquid soaps and paper towels. There was a hand hygiene poster displayed above all hand wash basins.

Equipment and medicines

We saw that the practice was well equipped to deal with a wide range of dental treatments. The equipment was well maintained and kept clean. The maintenance records we reviewed showed that servicing of equipment was undertaken in accordance with manufacturers' recommendations.

The practice held stocks of local anaesthetic required for dental procedures. This was held securely and stock recorded. When local anaesthetic was administered the batch number was recorded in a log with the patient's name. We were told that the practice was updating their dental record software to enable the batch number to be entered directly onto the patient's dental care record.

No other medicines were held at the practice. If a patient required a medicine this was prescribed by the dentist and the prescription was taken by the patient to a pharmacy of their choice. We noted that the prescription pads were held safely and securely.

Radiography (X-rays)

The practice had arrangements in place that were in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The practice had records that contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment.

Are services safe?

One of the dentists acted as the Radiation Protection Supervisor. We saw the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of 3 years.

Dental care records we saw showed when dental X-rays were taken they were justified and, reported upon. The practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. However, the practice was unable to demonstrate that they had undertaken an audit of the quality of the X-rays taken. This meant that patients could not be sure that the definition of the X-rays they had received were always of good quality enabling dentists to identify any cavities or other oral health issues.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients completed a full medical history and were asked if there were any changes to medical conditions or medicines taken before any course of treatment was undertaken. The dental care records we reviewed showed medical history had been checked. The five patients we spoke with all told us that the dentists asked them about their health and any medicines they were taking prior to commencing treatment.

The practice used current guidelines when making decisions on treatment and clinical risk. For example the requirement to take X-rays and the frequency of recall was based upon a full oral examination. Each time the patient received a dental check their dental care records were updated and decisions about their future treatment and check-up regime were noted.

Health promotion & prevention

The dental care records we reviewed, comments we received on CQC comment cards and patients we spoke with showed us that oral health and preventative measures were discussed with patients. Appointments with the dental hygienist were offered when appropriate and patients were given the option of taking up the offer. Products such as toothbrushes and high fluoride toothpaste were available for patients to purchase at the practice. There were health promotion leaflets available in the practice to support patients to look after their oral health. These included information about good oral hygiene.

The dentists working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. We spoke to two dentists on the day of our visit. They described to us how they carried out their assessment. The assessment began with the patient updating a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of oral cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

We noted that one of the dentists and the dental hygienist undertook visits to a local school to advise pupils on the importance of oral hygiene and looking after their teeth.

Staffing

There were enough staff to support the dentists during patient treatment. It was apparent by talking with staff that they were supported to receive appropriate training and development.

This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and other specific dental topics. Trainee dental nurses were enrolled on approved courses of study and the trainee we spoke with told us they were well supported in their training. This demonstrated that the provider was supporting the staff to deliver care and treatment safely and to an appropriate standard.

We spoke with members of staff. Two had been in post of over a year and they confirmed they had their learning needs identified through both informal discussions and their annual appraisal and they were encouraged to maintain their professional expertise by attendance at training courses.

We saw evidence of medical indemnity cover for the dentists and the nurse who were registered with the General Dental Council.

Working with other services

We discussed with the dentists how they referred patients to other services. Referral forms and responses were held in the dental care records. These ensured patients were seen by appropriate specialists. Dentists were able to refer patients to a range of specialists in primary and secondaryservices if the treatment required was not provided by the practice.

Systems had been put into place by local commissioners of services and secondary care providers whereby referring practitioners would use bespoke designed referral forms. This helped ensure the patient was seen in the right place at the right time.

When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. There was a system in place to ensure the information coming back from other services was entered in the dental care records to ensure the dentist saw this when they next treated the patient.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The five patients we spoke with said the dentists involved them in decisions about their care and treatment. The two dentists we spoke with had a clear understanding of consent issues. They stressed the importance of ensuring care and treatment was explained to patients in a way and language patients could understand.

Dentists we spoke with explained how they would take consent from a patient who suffered with any mental impairment, which may mean they might be unable to fully understand the implications of their treatment. The dentists explained if there was any doubt about the patient's ability to understand or consent to the treatment, then treatment would be postponed. They explained they would involve relatives and carers to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We saw that staff made significant effort to maintain the confidentiality of patient information. For example, reception staff avoided repeating patient names, or asked the patient for their date of birth, when taking telephone calls. This reduced the risk of other patients in the waiting room overhearing personal details. The dentists or nurses came to greet patients from the waiting room and take them to the dental treatment rooms for their treatment. The treatment rooms were situated so that conversations between patients and dentists could not be overheard by others in the waiting room. The computers in the practice were password protected and those at reception were positioned so that patients could not see the information on the screens.

The six patients who completed comment cards and the five patients we spoke with were all positive about the dentists treating them with care and concern. Parents were encouraged to accompany children during their treatment as were carers who visited with patients who required extra support.

We reviewed the practice returns from the friends and family recommendation test for a random seven months between April 2015 and March 2016. There had been 60 returns and all 60 patients recorded that they were either very likely or likely to recommend the practice to others.

Involvement in decisions about care and treatment

Information to enable patients to make decisions about their treatment was available in written formats. However, we were told by the dentists, and patients confirmed, that the emphasis was on verbally advising patients of the treatment proposed or options available. We saw that, after verbal explanation of treatment, NHS treatment plans were used to confirm the treatments proposed and that these were signed by patients. Dental care records we reviewed showed us that options were documented.

The five patients we spoke with and comments contained on CQC comment cards told us that patients felt they had sufficient time with the dentists and that the dentists took time to ensure treatment was fully explained along with oral health advice to help avoid future dental problems.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Information on the range of treatments available from the practice was available in the practice leaflet and displayed in the waiting room along with the opening times of the practice. The treatments were also displayed in the reception area and the costs for both NHS and private treatment were detailed alongside the treatments.

The practice provided continuity of care to their patients by enabling them to see the same dentist each time they attended. When this was not possible they were able to see one of the other dentists.

Patients new to the practice were required to complete a patient questionnaire so that the practice could conduct an initial assessment and respond to their needs. This included a medical history form. The dentists undertook a full examination when patients attended for their first appointment and this was documented in the patient record.

Tackling inequity and promoting equality

The practice was accessible to patients in wheelchairs and those with walking difficulties. The practice provided a car park with a designated bay for disabled parking close to the entrance. There was an automated entry door to assist patients with mobility difficulties. There was a lowered section of the reception desk where a patient using a wheelchair could locate themselves to speak with the reception staff. The main waiting room had sufficient space for a wheelchair or for pushchairs and prams. Dental surgery rooms were all located on the ground floor.

The practice did not have a hearing loop to assist patients who used hearing aids. Staff were not clear whether there was access to a telephone translation services. We were told there were very few patients registered whose first language was not English. Those who required a translator brought a relative or friend to support them. We saw that appointments were available outside of school hours.

Access to the service

The practice was open from 9am every morning. It closed at 6pm on a Monday, 5.30pm from Tuesday to Thursday and at 5pm on a Friday. Patients requiring an urgent appointment, when in dental pain, were able to get an appointment on the day they called or were able to speak to one of the dentists. If the urgent appointment slots were taken patients needing to be seen urgently were seen on a sit and wait basis. None of the patient comment cards or the patients we spoke with expressed any concerns about difficulty accessing appointments. There was a message on the practice telephone system which advised patients of the number to call for dental emergencies when the practice was closed.

Concerns & complaints

The practice had a complaints procedure. The practice manager was responsible for investigating and responding to any complaints the practice received. The complaints procedure was displayed in the waiting room. The practice did not detail their complaints procedure on the patient website. Staff we spoke with were clear in their understanding of the practice procedure and how they would support a patient who wished to lodge a complaint. We reviewed the one complaint the practice received in the last twelve months. This showed us that an investigation had been carried out. The patient received an honest and open response in a timely manner and an apology was given. We reviewed the NHS choices site for the practice. This showed us that seven patients had posted comments in 2015/16 about the service they received. Four were wholly positive but three contained complaints about the various aspects of the service. We noted that the practice had not taken the opportunity to respond to the last five patient comments posted on NHS choices.

Are services well-led?

Our findings

Governance arrangements

The practice and the provider had undergone significant management change in the last year. A new area manager was in post and the practice manager had only been in their role for three weeks prior to inspection. The new practice manager was responsible for the day-to-day management functions of the practice. The area manager came from a clinical background and supported the dentists with clinical management.

The provider had an appropriate range of policies and procedures in place to govern the practice. For example, health and safety and training and development. Most policies had been updated in the last year. However, we saw that others were only just being updated or introduced. For example, the significant event reporting procedure had only just been changed and staff were yet to be briefed on how to apply it. Staff were aware of where policies and procedures were held and we saw that these were easily accessible.

However, the practice had failed to identify that mandatory audits of infection control and X-ray quality had either not been completed or had been mislaid. They had also failed to adequately train staff in the checking of emergency equipment. This meant that infection control processes and the environment had not been formally reviewed to identify and mitigate any risks of cross infection. The equipment in place to respond to a life threatening medical condition had not been checked thoroughly because staff had not been appropriately trained.

Leadership, openness and transparency

The practice had a statement of purpose. There was a strong ethos of providing safe personal treatment and we saw that staff were committed to the ethos. Communication in the team was underpinned by team meetings which covered a wide range of topics. However, these team meetings had been held sporadically in the last year during the time of management changeover. Records were kept of the meetings. The newly appointed manager had a plan of bi-monthly staff meetings going forward.

Staff we spoke with told us they were encouraged by the new management team to put forward ideas. They also told us they were well supported to carry out their roles and responsibilities. Staff had job descriptions and were clear on the duties that were expected of them.

Staff we spoke with told us the practice had an open culture and that they would have no hesitation in bringing any errors or issues of concern to the attention of the dentists. None of the staff we spoke with recalled any instances of poor practice that they had needed to report. There was a culture within the practice, and within the provider organisation, that encouraged candour, openness and honesty.

Learning and improvement

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Training was completed through a variety of media and sources. Staff were given time to attend local training seminars and sourced other training opportunities online or through professional journals.

We found an audit of dental block efficacy had been undertaken in January 2016. There were templates available for audit of control of infection processes and X-ray quality. However, previous audits in these areas could not be located. One of the dentists showed us the methodology they had prepared for undertaking an audit of the quality of dental record keeping. The provider had recently introduced tracking systems for significant events and complaints and we saw the new process was available at the practice.

We noted that appraisals were used to identify opportunities for staff development. For example, the newly appointed practice manager told us that they had discussed their desire to take on greater responsibilities via their appraisal. They had increased their responsibilities in the last year. Once they demonstrated their competences they took the opportunity to apply for, and be appointed to, the post of manager. We saw that they had attended a two day management development course, organised by the provider, to prepare them for their new role.

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

The practice did not carry out their own surveys to gain patient feedback on the services provided. However, they

Are services well-led?

reviewed the feedback from the friends and family test and this was also shared with the provider organisation to review trends. However, we were told that the results were not fed back to patients.

The practice had not taken the opportunity to respond to comments posted by patients on NHS choices in the last eight months. We noted that the new practice manager and area manager were committed to developing stronger communication and feedback channels. For example the practice manager had a plan of bi-monthly staff meetings due to commence in April. They had only been in post for three weeks when our inspection took place.

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 17 HSCA (RA) Regulations 2014 Good governance **17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (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; **How the regulation was not being met:** • The registered person had failed to assess the risks of not completing audits of X-ray quality and measures aimed at reducing the risk of cross infection. • The registered person had failed to identify that staff completing checks of emergency equipment had not been appropriately trained to identify whether the equipment was in working order.