Gregory G Lai & Associates

Mr G Lai & Associates - Willesden

Inspection report

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Overall summary

We undertook a follow up focused inspection of Mr G Lai & Associates - Willesden on 5 May 2023. This inspection was carried out to review the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental advisor.

We had previously undertaken a comprehensive inspection of Mr G Lai & Associates - Willesden on 22 November 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe and well-led care and was in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can read our report of that inspection by selecting the 'all reports' link for Mr G Lai & Associates - Willesden dental practice on our website www.cqc.org.uk.

When 1 or more of the 5 questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

- Is it safe?
- Is it well-led?

Summary of findings

Due to the nature of concerns identified during the follow up inspection on 5 May 2023, we served a Notice of Proposal on the provider, proposing to vary a condition on their registration which specifies the locations they are authorised to carry on the regulated activities, so they are no longer authorised to carry on the regulated activities from the location Mr G Lai & Associates – Willesden. The provider has the right to make representations within 28 days of the date the notice was served on them.

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 22 November 2022.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 22 November 2022.

Background

The provider has 3 practices and this report is about Mr G Lai & Associates – Willesden.

Mr G Lai & Associates - Willesden is in the London Borough of Brent and provides NHS and private dental care and treatment for adults and children.

The practice is not fully accessible to people who use wheelchairs and those with pushchairs. The practice communicates this to new patients before booking, and signpost people with mobility issues to nearby practices. Car parking spaces are available near the practice.

The dental team includes the principal dentist, an associate dentist, a foundation dentist, a qualified dental nurse and a trainee dental nurse. The practice has 3 treatment rooms.

During the inspection we spoke with all members of the dental team. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Friday 9.30am to 6pm.

We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way to patients.

Summary of findings

- Ensure persons employed in the provision of the regulated activities receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Implement processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found that this practice was not providing safe care and was not complying with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report).

At the inspection on 5 May 2023 we found the practice had made the following improvements to comply with the regulations:

- The practice had updated their safeguarding policy, and this now included information about current procedures and guidance about raising concerns about abuse. The contact details of the Local Authority`s safeguarding board were displayed in the staff room. We saw evidence that staff had received safeguarding training at a level suitable for their role.

However, we found that in the following areas the practice was not complying with the relevant regulation. In particular:

- The practice infection control procedures did not reflect the guidance set out in the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05).
- There were no systems and processes in place to ensure the separation of instrument reprocessing from other activities by physical or temporal means. We observed a kettle and a mug in the dirty zone of the decontamination area used to process contaminated instruments. We had identified the same concerns during the comprehensive inspection on 22 November 2022. The practice informed us at the time that the kettle had been removed from the decontamination area. In addition, during the inspection on 5 May 2023 we noted that the cabinets above the dirty zone were filled with food items. A member of staff told us that when they needed a snack, they would take it from this area. We brought this to the provider`s attention and staff cleared out the cabinets by the end of the day. However, we were not assured that staff had identified the risks arising from the preparation of food and drinks in the area otherwise used to process dental instruments contaminated with bodily fluids.
- Systems and processes to ensure cleaned instruments were free from visible contamination were not effective. The instruments in the autoclave had dental cement and impression material residue. A member of staff confirmed that these had been cleaned. This was not in line with HTM 01-05 guidance which stated that the visual inspection process should ensure that the standards of cleaning achieved is satisfactory, and where contamination is present, flushing with a suitable disinfectant followed by thorough washing was necessary.
- The provider could not demonstrate that periodic safety checks, such as appropriate use of data logger or daily automatic control tests, and weekly residual air tests were carried out on the autoclave in line with the HTM 01-05 guidance. The last test strip in the autoclave log book was dated 22 November 2022, the date of the previous CQC inspection. Staff told us that they had implemented the use of a data logger immediately after the previous inspection. They also told us that they were not aware how to access information from the data logger. Furthermore, the account given by staff was inconsistent with the provider`s submissions in response to the summary of our key findings following the comprehensive inspection, where they provided a copy of a daily/weekly autoclave data logbook template and told us the practice would immediately implement the use of this. We did not see evidence that there were systems in place to ensure periodic tests were carried out to demonstrate the equipment reached the required temperature and pressure parameters. We further noted that the annual autoclave servicing was overdue, with the last service carried out on 13 April 2022. Following the inspection, the provider told us that they would format the memory stick containing the autoclave data and download the relevant software.
- The decontamination process demonstrated by staff did not reflect the guidance set out in HTM 01-05; for example:
- On the day we observed that staff did not wear appropriate Personal Protective Equipment (PPE), including eye protection and domestic gloves during the manual cleaning of dental instruments.

Are services safe?

- Dirty instruments were transported in unlidded containers.
- The enzymatic solution used to disinfect instruments was not measured to ensure the dilution recommended by the manufacturer was achieved.
- Instruments were scrubbed under running water.
- A dirty-to-clean workflow was not maintained; transportation boxes marked as 'Clean instruments' were kept in the dirty zone. Following the inspection the provider told us that these had now been moved to the clean zone.
- We observed high level of dust in the clean zone, and a soiled T-shirt tucked behind the autoclave, located in the clean zone.
- A handle to remove metal trays from the autoclave was kept in a box used to drain contaminated water from the autoclave.
- We observed staff cross-contaminating cabinets by touching drawer handles with dirty gloves previously used during the decontamination of instruments.
- Staff wore long sleeves and clothes otherwise worn outside the practice.
- The decontamination area did not have a dedicated hand-wash sink.
- Systems and processes to ensure that long-handled brushes and domestic gloves were replaced regularly were ineffective. The last entry on the 'Long Handled Brush and Heavy-Duty Gloves Replacement Log' was 21 February 2023. Staff told us that they did not wear the heavy duty gloves during the decontamination process because they were 'mouldy.' Following the inspection, the provider submitted an updated 'Long Handled Brush and Heavy-Duty Gloves Replacement Log' with entries after 21 February 2023. We noted that this was the same document we saw during the inspection and contained data that was not available on the day of the inspection.
- The long-handled brush used to scrub decontaminated dental instruments was kept in the same box with other sponges and wire wool brushes.
- There were no systems in place to ensure the decontamination room was cleaned regularly. The last entry on the 'Checklist for Decontamination Room' was '24/2'.
- We observed that the premises were visibly dirty and untidy with high level of dust in the treatment rooms and communal areas. The floor in surgery 1 was dirty and not coved to the wall to prevent accumulation of dirt where the floor meets the wall. Drawers and work surfaces were cluttered and not easily cleanable. In Surgery 1 we observed that there was a plastic cover on the intraoral unit exposure switch. Staff told us that they replaced this cover once a week. Cleaning was not thorough and the last entry on the cleaning checklist was '23/2'. Following the inspection, the provider told us that clinical areas had been decluttered, the plastic cover from the exposure switch removed and they now had spot checks in place.
- The practice did not have effective systems and processes in place to control the storage time of sterilised instruments.
- We found a large number of unsealed and undated sterilisation pouches containing elevators, forceps, handpieces, matrix band holders, scissors and scalers.
- Multiple pouches containing dental instruments were past their expiry date. For example, dates seen included 29/12/21, 20/12/2022, 26/9/2022.
- In Surgery 3 we saw 8 used self-seal sterilisation pouches with the adhesive strips intact. Staff told us that the dentist had used instruments from these pouches to treat service users on the morning of the inspection. This meant that instruments were taken and used from unsealed sterilisation pouches. Staff could not explain why the used single-use sterilisation pouches were kept after use. Following the inspection, the provider told us that the requirements around pouching sterilised instruments had been discussed in a team meeting, there were now spot checks in place and moving forward they would ensure that all sterilised items were adequately wrapped and dated.

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- The practice failed to ensure that single-use devices were only used during a single treatment episode and then disposed of. In Surgery 3 we found items intended for single use, including used endodontic files, burs and plastic impression trays. In Surgery 1 we observed a used single use impression tray in the same box with unused partial trays. Following the inspection, the provider told us that used single use devices had now been removed.
- The practice failed to ensure that hand hygiene could be practiced at key stages of the decontamination process, including before and after each treatment session, before and after removal of PPE, and following the washing of dental instruments. There was no dedicated hand-wash sink in the decontamination area and there was no hand soap in Surgery 1. Following the inspection, the provider told us that they were looking into the options of installing a hand wash sink in the decontamination area and hand soap had been placed by each sink in Surgery 1.
- The practice did not have effective systems to reduce the risk of Legionella and other bacteria developing in the water system. A Legionella risk assessment undertaken in April 2022 was made available for review. This made a number of recommendations, including Legionella Training required for the responsible person, the servicing of the air conditioning system, ensuring that the water system was kept clean and free from nutrients that can favour legionella bacteria to grow, removal of all dead legs where practicable and carrying out monthly hot and cold outlet temperature checks. The practice could not demonstrate that these recommendations had been acted upon. In particular, the last entry in the hot and cold-water temperature log was dated November 2022. Following the inspection, the provider submitted an updated monthly water temperature log with entries after November 2022. We noted that this was the same document we saw during the inspection and contained data that was not available on the day of the inspection.
- When we asked about the management of Dental Unit Water Lines (DUWLs) within the practice, a member of staff providing chairside support on the day admitted that they did not know what the requirements were in line with HTM01-05. Following the inspection, the provider told us that they had reinforced staff knowledge about the requirements relating to the management of DUWLs.
- Systems in place to ensure staff received the appropriate vaccinations, including vaccination to protect them from Hepatitis B were ineffective. We saw that 1 staff member received only 2 out of the required 3 doses and there was no evidence of antibody blood tests to indicate their immunity. In addition, the risks around this had not been assessed. Following the inspection, the provider told us that the third dose of Hepatitis B vaccination for the staff member who only had two doses was not due until 2025, however we were not provided evidence of this.
- The practice did not ensure that clinical waste was managed in line with the current guidance. We observed that clinical waste bins were not lidded, X-ray film holders contaminated with service users` saliva were not disposed of as clinical waste, the outside clinical waste bin was not secure and not locked and yellow sharps bins were not labelled and dated. Following the inspection, the provider submitted photographic evidence that the clinical waste bin was now locked, and they had installed foot operated lidded clinical waste bins. They further stated that the sharps boxes were now labelled and dated.
- The practice did not ensure that the management of fire safety was effective. A fire risk assessment undertaken in April 2022 was made available for review. This made a number of recommendations, including the periodic inspection, maintenance and testing of fire extinguishers, clearly signposting fire extinguisher ID signs fixed to the stand or the wall, keeping the fire logbook up-to-date, testing smoke detectors and alarms systems in line with the manufacturer`s instructions, inspecting fire compartmentation annually and carrying out any remedial action, and installing fire resistant doors. The provider could not demonstrate that all recommendations made in the fire risk assessment had been acted upon.
- The fire log book was not maintained, and periodic in-house checks of the fire safety equipment, including the fire alarm system and the emergency lighting system, had not been carried out. We asked about the protocols in place for periodic in-house testing and staff told us that they thought that the fire drill undertaken on 18 November 2022 covered all requirements in relation to periodic testing. Following the inspection, the provider submitted a weekly fire

safety equipment testing log dating back to 18 November 2022. We noted that this data was not available on the day of the inspection and was completed by the same member of staff who during the inspection told us that they were under the impression that the fire drill undertaken on 18 November 2022 covered all requirements in relation to periodic testing.

- There was no evidence that fire compartmentation, as recommended in the fire risk assessment, had been annually inspected and any recommended remedial action had been carried out.
- There was no evidence that fire resistant doors had been installed.
- We observed a large amount of combustibles, including cardboard boxes across the practice. Following the inspection, the provider submitted photographic evidence that these have now been removed.
- The 2 fire extinguishers positioned next to Surgery 3 were dated 2003, and there was no record to demonstrate they were regularly serviced. 2 of the 4 fire extinguishers next to the decontamination area stated 'overhaul'. In their response to our summary of key findings after the CQC inspection of 22 November 2022, the provider told us that new replacements and remedial work on the existing fire extinguishers had been arranged for 30 November 2022; however, there was no record of this work having been undertaken. Following the inspection, the provider submitted evidence that the 10-year overhaul service on the 2 carbon dioxide fire extinguishers had been completed on 30 November 2022. We were also provided evidence that a water and a powder extinguisher had been commissioned the same day. The provider further stated that the old fire extinguishers have now been removed.
- The rear fire exit was obstructed with buckets and a hoover. We identified the same concerns after the inspection on 22 November 2022. The provider submitted photographic evidence at the time that the fire escape route had been decluttered. We were not reassured that these improvements had been maintained. Following the inspection, the provider submitted photographic evidence that the items obstructing the rear fire exit had now been removed.
- Systems and processes to identify and mitigate the risks arising from the use of sharps were not effective.
- A sharps risk assessment dated 27 October 2022 was made available for review. We noted that this risk assessment was not reflective of the arrangements within the practice. The risk assessment stated that 'Safety Plus Needles are to be used'. These were not available in the practice on the day of the inspection.
- The risk assessment further stated, that '*Where safety plus needles are not used, needle guards for used for re sheathing needles are present*'. We asked a member of staff providing chairside support on the day to show us where the needle guards were kept in Surgery 2, but they were unable to locate them. This meant that needle guards were not in use on the day of inspection in Surgery 2. We noted that 3 needle guards available in Surgery 3 were kept in their original packaging, and they did not appear to have been used, or sterilised, which would be expected as these items were used during the treatment of patients.
- The practice could not demonstrate that they carried out risk assessments for hazardous materials used within the practice as per Control of Substances Hazardous to Health regulations 2002 (COSHH). We found that risk assessments had not been carried out for all hazardous materials and substances (e.g. Alpron, tray adhesive, Optiobond) used in the practice. Following the inspection the provider stated that the COSHH folder was available during the inspection with all individual risk assessments contained within the folder, however we identified on the day that some risk assessments were missing.
- Welooked at the general health and safety risk management protocols within the practice. A General Risk Assessment (undated) was made available for review. We noted that the findings of this documents were not reflective of the arrangements within the practice. For example, it stated that '*standard precautions and current infection control guidelines are followed', staff are 'immunised against hepatitis B and their responses checked*', '*fire routes and exits clear*',

Are services safe?

‘ *COSHH risk assessment present*’, ‘*thick rubber gloves present and disposed of regularly*’ and ‘*sharps bins wall mounted, signed and dated*’. These statements were not substantiated by our findings on the day of the inspection. We were not assured that the provider made suitable and sufficient assessment of risk to the health and safety of employees in line with the relevant regulations.

- We looked at the arrangements to manage medical emergencies. We noted that the medicine used to treat epileptic seizures (Buccolam) and the medicine to treat acute anaphylaxis (Adrenaline 1mg/ml) expired in April 2023. The practice made arrangements to replace these immediately, however, we were not assured that the systems and processes in place to check medical emergency drugs and equipment were effective to ensure they were replaced in a timely manner once they reached their expiry date. In addition, the fridge temperature checks to ensure the emergency medicine used to treat severe low blood sugar (Glucagon) was stored in line with the manufacturer`s guidance were not effective. The last entry in the ‘Fridge Temperature Audit’ was on 25 April 2023. Following the inspection, the provider submitted a fridge temperature log for dates between 26 April 2023 and 9 May 2023. We noted that this data was not available on the day of the inspection.
- There were no records to show that the 3-yearly calibration and dosage tests had been carried out on the intraoral unit in Surgery 2. Following the CQC inspection on 22 November 2022 the provider told us that this service had been completed; the report was not available for review during the inspection on 5 May 2023. Following the inspection, the provider submitted the cover page of the critical examination and acceptance test on the intraoral unit in Surgery 2, dated 24 November 2022. However, we were not provided a copy of the findings. The provider told us that they had arranged an engineer to review the findings in each critical examination report.
- The 3-yearly calibration and dosage tests undertaken on 15 June 2022 found that the measured patient entrance dose, both for adult and child mandibular molar were greater than the respective recommended National Diagnostic Reference levels (NDLRs) and therefore both should be reduced to an acceptable level. The report stated that the provider should consult their appointed medical physics expert (MPE) to determine the practicability of adequately reducing patient entrance doses. The practice could not demonstrate that they have consulted their MPE. In addition, the report stated that rectangular collimators should be fitted on the X-ray sets in Surgery 1 and Surgery 3. These had not been fitted at the time of our inspection.
- We found expired dental materials in Surgery 3. These included a dental cement which expired in March 2021 and anaesthetic cartridges expired in April 2023.

Are services well-led?

Our findings

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

At the inspection on 5 May 2023, we found the practice had made the following improvements to comply with the regulations:

- The practice had implemented a system to track and monitor referrals.
- The practice has improved the recruitment process to ensure the relevant documentation, including proof of identity including a recent photograph, a copy of enhanced criminal record certificate and full employment history was obtained from new members of staff.

The practice had also made further improvements:

- The provider ensured that clinical staff improved their awareness of the requirements of the Mental Capacity Act 2005.
- Clinicians ensured that when carrying out patient assessment, they were in compliance with the current legislation and they took into account relevant nationally recognised evidence-based guidance.

However, we found that in some areas the practice was not complying with the relevant regulation. In particular:

- There was ineffective leadership which impacted the practice`s ability to deliver safe and effective care. The principal dentist could not assure us that they understood the risks pertaining to the lack of oversight.
- The principal dentist was responsible for compliance with the regulations, including fire safety, Legionella and safeguarding. They spent one day a week at the practice, and we were not assured that there were sufficient deputising arrangements in place to ensure that systems and processes were operated in line with the regulations in his absence. Following the inspection, the provider told us that they had now hired a practice manager to oversee compliance.
- Staff told us that the practice had regular meetings. The most recent meeting record was from October 2022. A member of staff told us that they have had further practice meetings since then and they still had to 'type up' the minutes of those meetings. We were not assured that there were effective systems in place to review practice policies and disseminate changes to staff to ensure that the quality and safety of the services provided were assessed, monitored and improved.
- Following the inspection on 22 November 2022, the provider submitted their response to our summary of key findings. In their response they stated that the decontamination area had been cleaned and was dust free and the kettle had been removed. They told us that logs were in place for weekly replacement of long handled brushes and gloves. They informed us that weekly tests were carried out on the autoclave and staff had been updated of the decontamination process and they understood the requirements. The provider submitted photographic evidence that the fire exits had been cleared and were now easily accessible. During the inspection on 5 May 2023, we found that the improvements the provider told us they would immediately undertake were either not implemented or not maintained. We found similar concerns during the follow up inspection, and identified a failure to respond adequately to concerns raised by us during the inspection on 22 November 2022.
- The provider failed to ensure that dental care records were stored securely. We observed a large number of patient care records piled up on the top of the desk situated in the corridor at the bottom of the steps leading to Surgery 2 and Surgery 3, and in Surgery 1. This meant that service users entering the premises had potential access to confidential information, including medical records. Following the inspection, the provider told us that all record cards have now been removed from Surgery 1 and the office area and they were now stored securely.

Are services well-led?

- Arrangements for supervision of staff were not effective in that those overseeing trainee dental nurses did not identify shortcomings in the infection control process and did not ensure that the decontamination and sterilisation of instruments were carried out in line with the current guidance.
- Systems and processes to monitor staff training were ineffective. The training log did not contain up to date information of continuing professional development undertaken by staff and did not include all members of staff.

The practice did not ensure that there were effective systems in place for seeking and learning from patient feedback with a view to monitoring and improving the quality of service. 4 Friends and Family Test reviews were made available for review. Staff told us that they believed these were completed in March 2023. However, there were no systems in place to review feedback for trends to identify areas of improvement.

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 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that persons employed in the provision of regulated activates received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Arrangements for supervision of staff were not effective in that those overseeing trainee dental nurses did not identify shortcomings in the infection control process and did not ensure that the decontamination and sterilisation of instruments were carried out in line with the current guidance. Regulation 18 (2)

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular; • There were no systems and processes in place to ensure the separation of instrument reprocessing from other activities by physical or temporal means. • Systems and processes to ensure cleaned instruments were free from visible contamination were not effective. • The provider could not demonstrate that periodic safety checks, such as appropriate use of data logger or daily automatic control tests, and weekly residual air tests were carried out on the autoclave in line with the HTM 01-05 guidance. • The decontamination process demonstrated by staff did not reflect the guidance set out in HTM 01-05. • The premises were visibly dirty, untidy with high level of dust in the treatment rooms and communal areas. • The practice did not have effective systems and processes in place to control the storage time of sterilised instruments. • The practice failed to ensure that single-use devices were only used during a single treatment episode and then disposed of. • Systems and processes in place to reduce the risk of Legionella and other bacteria developing in the water system were not effective. • The provider did not consider the risks of the transmission of Hepatitis B.

This section is primarily information for the provider

Enforcement actions

- The practice failed to ensure that clinical waste was managed in line with the current guidance.
- The provider failed to ensure there were proper fire safety measures in place.
- The provider did not have suitable arrangements to identify and mitigate the risks arising from the use of sharps.
- The provider could not demonstrate that they carried out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health regulations 2002 (COSHH).
- The provider did not have suitable and sufficient assessment of the risk to the health and safety of employees and of persons using the service.
- Systems and processes in place to check medical emergency drugs and equipment were not effective to ensure they were replaced in a timely manner.
- The fridge temperature checks to ensure the emergency medicine was stored in line with the manufacturer`s guidance were not effective.
- The provider could not demonstrate that they acted on the recommendations made in the 3-yearly calibration and dosage tests for the intraoral X-ray units.
- We found expired dental materials in Surgery 3.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems or processes that ensured that enabled the registered person to assess, monitor and improve the quality and safety of the service being provided. In particular:

This section is primarily information for the provider

Enforcement actions

- Systems in place to review practice policies and disseminate changes to staff were ineffective.
- The provider failed to respond adequately to concerns raised by us during the inspection on 22 November 2022. Improvements the provider told us they immediately undertook were either not implemented or not maintained.

There were systems or processes that operated ineffectively that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular

- Patient care records were not stored securely.

There was additional evidence of poor governance:

- There was ineffective leadership which impacted the practice`s ability to deliver safe and effective care.
- Leaders did not have sufficient oversight of the day to day activities of the practice and there were no sufficient deputising arrangements in place to ensure that systems and processes were operated in line with the regulations in their absence.

Regulation 17 (1)