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Addiscombe Dental Surgery

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 14 July 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

We found that this practice was not 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

Addiscombe Dental Surgery is located in the London Borough of Croydon. The premises consist of two treatment rooms. One of the surgeries is located on the ground level and the other surgery is on the upper level where stairs from the reception led to the room. There is no separate decontamination room. The upper level surgery has a decontamination area. There are two separate toilet facilities for staff and patients, two waiting areas, a small reception area, and an administrative office on the third level. Stairs from the reception level led to a basement level where there were two store rooms.

The practice provides NHS and private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations, treatment and oral hygiene.

The practice staffing consisted of one dentist (who was the owner and manager), two trainee dental nurses and one part-time hygienist. One trainee dental nurse works on reception and the other with the dentist or hygienist.

The practice is open Monday 9:00am to 2:00pm, Tuesday and Thursday 9:00am to 5:30pm and Friday 8:00am to 2:00pm. The hygienist works on Tuesday's only.

We carried out an unannounced comprehensive inspection on 14 July 2015 in response to concerns that were reported to CQC about the fundamental standards of quality and safety that were not being met. On the day of our inspection the dentist (who was also the manager

Summary of findings

and provider) was on leave. When we arrived, staff contacted the provider on the telephone and we spoke to them and explained we would be carrying out a comprehensive inspection.

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

We reviewed four NHS Friends and Family test cards completed by patients and one review posted on the NHS Choices website. Patients gave positive views about the care and experience of the practice.

Our key findings were:

- Staff told us the relevant checks to ensure that the persons being recruited were suitable and competent for the role, however there were no records kept.
- The practice worked well with other providers and completed all the relevant information required.
- The practice did not have robust arrangements in place to manage the risk of spread of infection.
- The practice did not have robust arrangements for disposal of clinical waste.
- There were limited governance arrangements in place to guide the management of the practice.
- The practice did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- The monitoring arrangements and audits were not effective in improving the quality and safety of the services
- Appliances and fixtures and fittings in the premises were not being suitably maintained.

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

- Review the practice's infection control procedures and protocols 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 a safe system is in place to monitor dental materials
- Ensure a safe system is in place to monitor emergency medicines.
- Ensure waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Review the practice's protocols for undertaking radiography giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- Review governance arrangements including the effective use of risk assessments, audits, such as those for infection control, radiographs and dental care records, and staff meetings for monitoring and improving the quality of the care received.
- Review the suitability of all areas of the premises and the fixtures and fittings in the treatment rooms.
- Ensure recruitment checks are recorded and evidence is documented.
- Ensure all staff receive induction and performance appraisals and are suitably supported in undertaking their activities.

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

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 not carried out health and safety audits or risk assessments with a view to keeping staff and patients safe. They did not have proper arrangements in place to deal with medical emergencies. There were poor systems in place to reduce the risk and spread of infection. The practice had not kept a radiation protection file in relation to the use and maintenance of X–ray equipment. The provider could not confirm that suitable checks had been completed when staff were recruited. Although there was a system in place for reporting and learning from incidents, this was not followed through to make improvements.

The provider informed us shortly after the inspection, that they had suspended their appointment list and had ensured that no patients would be treated in the practice until all the concerns raised by us about the suitability of the premises, infection control procedures, medicines and equipment had been rectified.

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).

We found dental care records for patients to be incomplete. There was no information about the consent from patients recorded. There was no clear process for a formal induction being done or recorded and staff told us they were not aware of some of the practice policies and procedures in place.

Are services caring?

We found that this practice was not providing caring services in accordance with the relevant regulations.

We observed patients privacy may not have been protected. People in reception were able to here private conversations from the surgery. We also noted that the day list with patient's names and dates of birth was on display on the wall where other people could observe this.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of people with disabilities had been considered in terms of accessing the service. The practice had a system in place to schedule enough time to assess and meet patients' needs. Patients were invited to provide feedback via the use of the 'Friends and Family Test', in the waiting area. There was a clear complaints procedure and information about how to make a complaint was displayed in the waiting area.

Are services well-led?

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

The practice did not have effective governance arrangements in place. There was a significant lack of risk assessments and practice policies and procedures for staff to refer to for guidance. There were no formal staff meetings to discuss within the practice, priorities, lead roles or follow up actions from issues raised by the manager and staff. We found that none of the practice staff had undergone any refresher training in information governance.

Addiscombe Dental Surgery

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection on 14 July 2015 in response to concerns that were reported to CQC about the fundamental standards of quality and safety that were not being met. On the day of our inspection the dentist (who was also the manager and provider) was on leave. When we arrived, staff contacted the provider on the telephone and we spoke to them and explained we would be carrying out a comprehensive inspection. We reported our findings by telephone to the provider shortly after the inspection as the provider was out of the country.

The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

During our inspection visit, we reviewed policy documents and patients dental care records. We spoke with three members of staff, including the provider by telephone. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the dental staff carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed the practice comment cards completed by patients and reviews posted on the NHS Choices website. Patients gave positive views about the care and experience of the practice.

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

There was a system in place for reporting and learning from incidents, however there was no policy for staff to refer to and the process was not followed through to make improvements. For example, there had been an accident involving a needle stick injury reported in June 2015. The records explained the injured dental staff had gone to the occupational health department at the local hospital and had all the necessary checks to ensure they were not infected by any blood borne viruses. We saw no record of how the patient who was involved during the injury had been risk assessed or if they had been informed about the needle stick injury. Also, we were told the manager had offered to purchase needle guards to minimise the risk of a needle stick injury but this was not followed through.

The staff we spoke with confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result. We noted that the accident records did not show how the communication with the patient was handled during and after the needle stick injury.

Although staff understood the process for accident and incident reporting in the practice there was no clear knowledge of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). They confirmed there had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team which were on display in the office. The staff we spoke with were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. The dentist was the safeguarding lead and we saw evidence that they had completed safeguarding training in April 2012. However, we could not check if other members of staff had completed safeguarding training as no records were available. Staff we spoke with confirmed they had completed the training.

There was no information available to staff about the 'whistle blowing' procedures if they wanted to raise concerns about the practice or management in confidence with external bodies.

The practice had not carried out health and safety audits or risk assessments with a view to keeping staff and patients safe. For example, we saw in ground floor surgery there was an unsafe air conditioning system that was being used and there were rips in the flooring, cabling was not cased and there was a hole in the flooring where the reception staff sat that was covered by cardboard. We found the portable electrical appliances had not been checked for safety. The practice had not carried out risk assessments to minimise and prevent accidents that could potentially be avoided.

Medical emergencies

The practice did not have proper arrangements in place to deal with medical emergencies. They did not have suitable emergency equipment in accordance with guidance issued by the British National Formulary (BNF) and the Resuscitation Council UK. They did not have all the relevant emergency medicines and where medicines were present these were all found to be out of date apart from aspirin that was in date. The medical oxygen cylinder had expired in 2009. There was no automated external defibrillator (AED) or a risk assessment carried out for not having one. (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).

Staff had not received training in emergency resuscitation and basic life support in the last 12 months. We saw no records to evidence any training. The staff we spoke with told us they would call the manager who was a dentist and the owner and contact the emergency service if there was an emergency event.

We saw no evidence of medicine and emergency equipment checks being completed.

Staff recruitment

The practice staffing consisted of one dentist (who was the owner and manager), two trainee dental nurses and one hygienist. The staff we spoke to on the day told us the manager carried out relevant checks to ensure that they were suitable and competent for the role. This included the checking of qualifications, identification, registration with

Are services safe?

the General Dental Council (where relevant), references and checks with the Disclosure and Barring Service (DBS). However, there were no records to confirm these checks had been completed. The staff had confirmed they had completed all the necessary checks before starting work.

We requested evidence of the completed checks to be sent to us shortly after the inspection, but the manager had not done this.

Monitoring health & safety and responding to risks

There were no proper arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We saw there was a COSHH file, however only three dental materials had been recorded and these were not complete with notes of the risks to people that would be associated with hazardous substances. There was no information recorded that described how to minimise the risks. The staff we spoke with were not aware of the file being incomplete. They had a vague understanding of COSHH and told us the manager was responsible for updating the file.

The practice did not have a formal system in place to demonstrate how it responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA issue alerts to healthcare professionals, hospitals and GP surgeries to tell them when a medicine or piece of equipment is being recalled or when there are concerns about the quality that will affect its safety or effectiveness.

The practice did not have a business continuity plan in place to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were poor systems in place to reduce the risk and spread of infection. There was no infection control policy for staff to refer to. We saw no protocols and procedures displayed or available that staff could use for guidance around the decontamination of dental instruments, hand hygiene, use of personal protective equipment, and the segregation and disposal of clinical waste. The dentist who was also the manager was the infection control lead. We saw evidence that they had completed decontamination training in November 2014 last.

When we examined dental instruments we saw many instruments had not been cleaned properly leaving residues of cement still present and others were rusty and looked old. We found many dental burs that were used for drilling teeth to be unclean and rusty and not stored correctly leaving them at risk for spread of infection. There were many instruments, including syringes for administering local anaesthetic, that were not pouched or stamped with expiration dates and were in the surgery drawers. We also found instruments in a plastic container in the stock cupboard. Staff told us these had been through the decontamination and sterilising process but could not tell us when.

The local anaesthetic syringes were old and worn. We noted that there had been a needle stick injury in June 2015. There was no assessment made to review if the syringes had contributed to this accident. There were no needle guards present.

We observed the decontamination processes in both treatment rooms. There was one sink in the ground floor surgery where staff scrubbed instruments; however we noted there was no removable bowl to allow for clean rinsing and the sink was unclean with a rusty drain. Also, there were no heavy duty gloves used for cleaning. Instruments were left in a cleaning solution until lunch time when they were transported to the second surgery where the autoclave was kept. The container for transporting instruments did not have a sealable lid. Staff told us they used another plastic cover for the box. We saw this was not a suitable fit. This showed there was a risk of spread of infection during the process of transporting instruments.

During our observations we noted that in the upper level surgery where the autoclave was kept, there was a magnifying glass with a light and an ultrasonic bath that was unplugged. The trainee dental nurse told us the manager had not explained the use for these or its importance for checking for debris on dental instruments therefore they never used it.

In the second surgery on the upper level we observed the dirty and clean zones were well maintained and the correct processes being followed by the hygienist when decontaminating used dental instruments. We saw they used the magnifying glass and the ultrasonic bath before placing instruments into the autoclave.

The premises were not clean and tidy. The ground floor surgery had ants crawling through the window sill. The flooring had rips and there was dirt and dust and cabling

with no casing, squeezed into the corner against the cabinets of the surgery. The work tops looked cluttered especially around the sinks. We saw boxes of gloves and face masks left on the window ledge next to the sink.

The reception area had a few stairs that led to a lower basement level. We saw, in this area, eight orange bags full of clinical waste that had not been collected. One bag was not securely tied and was full of clinical waste stored in an area where patients, especially children, could get access. There was a damp patch under one bag that looked like it had leaked fluids. There was no yellow bin kept to store the clinical waste securely. When we reviewed the clinical waste records we saw records were incomplete and there were no consignment notes for any recent collections. When we asked staff on the day about the collections we were informed collections were not regular and on an ad-hoc basis every couple of months.

The waste was collected on the day of our inspection although we noted that the yellow sharps bin remained full and uncollected.

There was a storage room on the basement level at the back of the practice that had a potent smell of damp. This was where the working compressor was stored for the dental equipment that supplied the surgeries. The door was kept closed for security and the room did not have suitable ventilation. This had not been assessed for risks to the premises or people in the practice.

There was also another store room on the basement level that was used for storing cleaning materials and equipment. Although the practice had implemented the national guidance on colour coding equipment, the mops looked dirty and over used implying they had not been changed for some time. We noted there were cleaning schedules posted up on the display wall outside the store room, however these dated back to 2013.

The practice had not had a legionella risk assessment completed (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The hygienist told us they flushed the water systems regularly during the day that they worked. The dentist who was also the manager informed us they flushed the waterlines three times a day when they were working.

The manager informed us shortly after the inspection, no patients had been treated since the inspection and until a deep clean had been conducted including a visit by pest control services to remove the ants, and all the instruments had been cleaned, checked and put through the decontamination processes, they had not treated any patients. They confirmed they had undertaken a risk assessment to assess the practice to be safe and clean before they started treating patients again.

Equipment and medicines

We found that the equipment used at the practice was not regularly serviced and well maintained. For example, X-ray equipment had not received the necessary checks and the portable appliance testing (PAT) was not completed in accordance with good practice guidance.

We found dental materials in the ground floor surgery and stock cupboard had expiry dates ranging from 2006 to before June 2015. There were at least eight items in the surgery that we found to be out of date. Staff told us the manager was responsible for managing dental stock and materials. When we looked in the drawers we saw local anaesthetic cartridges were taken out of the blister packs and left in the box. This exposed the cartridges to damage and could potentially be unsafe to use.

Some dental medicines were stored in a fridge alongside staff members' food and drink. The practice was not monitoring and recording the fridge temperature. Therefore staff could not be sure that medicines stored in the fridge had been maintained in line with manufacturer's guidance and there was a risk that they had become ineffective.

Prescription pads were kept securely away from the potential of abuse; however no logs were maintained of the pads that had been issued.

Radiography (X-rays)

The practice had not kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There was no Health and Safety Executive notification, no inventory of all the X-ray equipment, no critical examination packs of all X-ray sets used in the practice, no acceptance test for new installations of X-ray sets and no maintenance logs within the last three years. These are all requirements for practices carrying out radiography on site must undertake to comply with legal obligations under The

Are services safe?

Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IR(ME)R). There were no local rules relating to the equipment either on file or displayed by the equipment.

We saw no evidence of training records on file for training pertaining to IR(ME)R 2000. The practice had no radiation protection advisor (RPA) registered.

The manager informed us shortly after the inspection an engineer was booked to service the equipment on 27 July 2015.

The provider informed us shortly after the inspection, that they had suspended their appointment list and had ensured that no patients would be treated in the practice until all the concerns raised by us about the suitability of the premises, infection control procedures, medicines and equipment had been rectified.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection we checked dental care records to confirm the findings. We found that the records were partially completed. Medical histories was kept up to date, patient's gum health and soft tissues (including lips, tongue and palate) was assessed.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action.

The records where treatments had been given did not include local anaesthetic details such as the type, site of administration, batch number and expiry date. There was no justification or grading's recorded for X-rays therefore no quality assurance of images. There was no record of consent, treatment options that had been discussed or the costs advised. There had been no records of audits completed to identify areas for improving.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The hygienist told us they discussed oral health with their patients, for example, effective tooth brushing and dietary advice. They identified patients' smoking status and recorded this in their notes. This prompted them to provide advice or consider how smoking status might be impacting on their oral health.

We observed that there was not a wide range of health promotion materials displayed; we found only a leaflet on smoking and however this was away from the main waiting area and not easy to access.

Staffing

Staff told us they had received appropriate professional development and training in relation to maintaining their registration; however they felt there were no policies and procedures training from the manager. They told us the training they had received covered all of the mandatory requirements for registration issued by the General Dental Council. This included safeguarding and infection control.

We found there were no records kept of the up to date training that staff had received, inductions that had been completed or annual appraisals to review career goals.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. The dentist completed a template form that included patients' details and dental concerns. The practice kept a record of the referral on the computer system and in the dental record. When the patient had received their treatment they were discharged back to the practice for continued care and monitoring.

Consent to care and treatment

The dental staff we spoke with were aware of the Mental Capacity Act (2005). They could explain the general principles and described to us the responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. However, there were no training records to confirm if staff had completed training. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

The dental record cards we reviewed did not have any details of consent recorded.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff were professional and inviting patients in for their appointments. However, we observed one patient that came in for their appointment was left in the waiting area unattended to while staff remained in the upper level surgery treating a patient. The patient was left alone for around 12 minutes before someone saw them in reception.

Dental care records were stored in a paper-based format. Paper records were stored in lockable filing cupboards in the reception area. However, we noted this remained open when staff on reception had stepped away from the desk to assist in the treatment room.

We noted that there was an opening in the walls at the top corner between the ground floor surgery and the reception area. This allowed people in the reception area to hear conversations between the patient and the dentist about dental health and any other private matters. We also noted that the day list with patient's names and dates of birth was on display on the wall where other people could observe this.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS dental charges and fees. Staff told us that they took time to explain the fees and treatments available. We observed staff on reception politely and calmly explaining the details of the fees and how to claim for help with paying dental charges.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The staff on reception gave a clear description about which types of treatment or reviews would require longer appointments. We were told that the dentist used the practice computer to indicate the type of treatment required so that the receptionist knew how long the appointment needed to be. The dentist also specified the timings for some patients when they considered that the patient would need an appointment that was longer than the typical time.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups and had met some of the requirements. For example, the practice was wheelchair accessible with level access to the reception area and treatment room. The toilet was also suitable for wheelchairs and included appropriate hand rails. There was a translation line staff could call for communicating with patients who did not have English as their first language. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The staff told us they did not find any problems when communicating with patients because they were usually accompanied by someone who could help translate. We noted there were no aids available for people with visual impairments or hearing problems. Staff told us they would book longer appointments for patients where this was appropriate.

Access to the service

The practice is open Monday 9:00am to 2:00pm, Tuesday and Thursday 9:00am to 5:30pm and Friday 8:00am to 2:00pm.

We asked the staff on reception about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access out of hours emergency treatment. The dentist kept some gaps in their schedule on any given day which meant that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. We saw there was a notice displayed advising patients to speak to the practice manager if they wanted to make a complaint. The staff told us the manager was responsible for leading investigations following any complaints and that they would seek advice from the dentist following any clinical complaint. However, there were no formal or informal complaints recorded therefore staff were unable to demonstrate any learning from complaints.

Are services well-led?

Our findings

Governance arrangements

The practice did not have effective governance arrangements in place. There was a significant lack of risk assessments and practice policies and procedures for staff to refer to for guidance.

Staff told us there were no inductions under the new provider and they did not feel they understood enough about the new ways of working. They were not clear who was responsible for some of the monitoring and practice processes.

There were no formal staff meetings to discuss within the practice, priorities, lead roles or follow up actions from issues raised by the manager and staff.

Leadership, openness and transparency

The staff we spoke with told us they felt supported to pursue development opportunities. The trainee dental nurse told us they had received one to one supervisions. If they had any questions they felt open to talk to the manager and other members of the team.

Throughout the inspection process the manager and staff cooperated in an open and transparent way and learning from the process and were open to making improvements where necessary.

Learning and improvement

We found that staff did not receive appropriate professional development. We found that staff had a lack of awareness about the practice's information governance. There was no proper system in place for recording training that had been attended by staff working within the practice. There was no evidence of an induction programme to the practice. There was no evidence that the practice had a programme of clinical audit in place. The practice had no systems in place to share learning about complaints or incidents with a view to making improvements to patients care.

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

The practice had collected feedback through the use of 'NHS Friends and Family Test' and 'Patient Satisfaction Survey'. The NHS Friends and Family Test forms were left in the waiting area. We counted four forms had been completed. All patients ticked 'likely to recommend' the practice and commented positively about the dentist and staff. We also saw

Patient Satisfaction Survey forms had been completed but these dated back to March 2013.

There was no further recent survey conducted to receive patients' feedback.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured that services users were treated with dignity and respect by ensuring privacy.** **Regulations; (10) (1), (2) (a).**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider had not ensured that care and treatment were provided in a safe way for service users.** **Regulations; (12) (1), (12) (2) (a),(b),(c),(d), (e), (f),(g),(h).**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured that the premises and equipment were clean, secure and well maintained for care and treatment of service users.** **Regulations; (15) (1) (a),(b),(c),(d),(e),(f), (15) (2).**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	The provider did not have effective systems in place to : · Assess, monitor and improve the quality and safety of the services provided. · Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. · Ensure that their audit and governance systems were effective Regulation (17) (1), (17) (2), (a),(b),(c),(d) (i) (ii),(e),(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 The provider had not maintained records to ensure the staff employed were fit and proper persons for the post. Regulations; (19) (3), (a),(b).