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Derby Road Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 October 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

Derby Road Dental Practice is a private dental practice in Croydon. The practice is set out over two floors. There is one dental treatment room and a separate decontamination room for cleaning, sterilising and packing dental instruments. In addition there is a reception and waiting area for patients.

The practice is open 9.00am – 6.00pm Monday to Fridays and appointments are available on Tuesday, Wednesday and Fridays during these times.

The practice has one dentist and is supported by a trainee dental nurse (who also provides reception duties).

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

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 33 patients. These provided a positive view of the services the practice provides. Patients commented on the quality of care, the friendliness and professionalism of all staff, the cleanliness of the practice and the overall quality of customer care.

Our key findings were:

Summary of findings

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment. Leadership was clear and roles and responsibilities well defined.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were in place but published guidance was not being fully followed. Clinical waste was not always being disposed of appropriately.
- The practice had a safeguarding lead with information available to staff to refer to. Staff demonstrated knowledge of safeguarding.
- The practice had a system in place for reporting incidents which the practice used for shared learning.
- Dentists provided dental care in accordance with current professional and National Institute for Health and Care Excellence (NICE) guidelines. However staff did not have up to date training for some procedures they were performing.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- The servicing of equipment was not being completed in a timely way.
- Risks associated with undertaking dental procedures under conscious sedation, re-use of single-use instruments such as dental burs and disposal of dental waste had not been recognised and suitably mitigated.

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

- Ensure suitable governance arrangements are in place and an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure the practice's protocols for conscious sedation including training requirements are suitable taking into account guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry. Department of Health 2003.
- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure 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).

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

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

- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review the procedures in place for the servicing of equipment ensuring that equipment is serviced at timely intervals.

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?

No action

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

Systems were in place for the provider to receive safety alerts from external organisations and they were shared appropriately with staff. Lessons learnt were discussed amongst staff. A policy was in place for suitable pre-employment checks to be carried out. There was an appointed safeguarding lead and all staff had completed safeguarding training.

Dental instruments were decontaminated suitably; however single use items were being re-used and clinical waste was not always being disposed of appropriately.

Medicines were available in the event of an emergency. There was medical oxygen and staff had access to an automated external defibrillator (AED) in the event of a medical emergency. Regular checks were carried out to the defibrillator and oxygen cylinder although the checks were not being logged.

Are services effective?

No action

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

There were suitable systems in place to ensure patients' needs were assessed and care and treatment was delivered in line with published guidance. Patients were given relevant information to assist them in making informed decisions about their treatment, and consent was obtained appropriately. Staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005. Referrals were made appropriately.

Staff were up to date with their CPD requirements. The practice maintained appropriate dental care records and patient details were updated regularly. Information was available to patients relating to health promotion and maintaining good oral health.

Are services caring?

No action

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

We received feedback from 33 patients via completed Care Quality Commission comment cards and speaking with patients on the day of the inspection. Feedback from patients was very positive.

Patients stated that they were involved with their treatment planning and were able to make informed decisions. We saw examples of equipment used to make

Summary of findings

the patient experience more comfortable and considerate of patients' needs. Patients referred to staff as being caring, empathetic, and professional and treating them with dignity and respect. They felt involved in their treatment and gave examples of where staff had ensured they understood treatment.

Are services responsive to people's needs?

No action ✓

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

The service was aware of the needs of their patient population and took those these into account in how the practice was run. Reasonable adjustments were made for patients when necessary. Patients could access appointments and urgent and emergency care was provided when required.

The practice had level access into the building but the dental surgery was upstairs and there was no lift for people with restricted mobility or for wheelchair users. Staff told us that they had arrangements in place with other practices in the local area that were wheelchair accessible which they could refer people to.

There were systems in place for patients to make a complaint about the service if required.

Are services well-led?

Requirements notice ✗

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

The practice held various informal meetings for the smooth running of the practice. Staff told us they were happy with the way information was shared with them and arrangements that existed for them to be informed. Audits were being completed regularly. However, risks associated with undertaking dental procedures under conscious sedation, re-use of single-use instruments such as dental burs and disposal of dental waste had not been recognised and suitably mitigated.

Servicing of equipment was not being carried out at timely intervals.

The provider assured us following our visit that they would address these issues and put immediate procedures in place to manage the risks. We have since been sent evidence to show that improvements are being made.

Derby Road Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

The inspection was carried out on 26 October 2016 by a CQC inspector who was supported by a specialist dental adviser.

Prior to the inspection we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose and the details of their staff members including proof of registration with their professional bodies.

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 principal dentist demonstrated an awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there were no serious incidents that required reporting over the past 12 months.

We spoke with the principal dentist about the handling of incidents and the Duty of Candour. The explanation was in line with the duty of candour expectations. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). The principal explained that relevant alerts were discussed with staff as and when received.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the safeguarding lead and acted as a point of referral. There was a written child protection policy but no written safeguarding policy for adults. The details of the local authority safeguarding team were displayed in the reception as well as in the staff policy folder. Training records showed that staff had received safeguarding training for both vulnerable adults and children. Both staff we spoke with demonstrated an awareness of safeguarding issues.

The principal dentist told us that there had been no safeguarding incidents that had required referral to the local authority.

The dentist was responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

The dentist was following guidance from the British Endodontic Society relating to the use of rubber dam for root canal treatment. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured].

Medical histories were reviewed at each subsequent visit and updated if required. During the course of our inspection we checked dental care records to confirm the findings and saw that medical histories had been updated appropriately.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff had received training in how to use this equipment. On the day of our inspection the defibrillator was not working. The principal dentist advised us it had got broken few days before our inspection and provided evidence of the pending repair. As an interim measure they had made arrangements with a neighbouring service to use their AED in the event of a medical emergency.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell. Emergency medicines were checked on a weekly and monthly basis. Staff told us they also checked the medical emergency equipment but they did not maintain logs of these checks.

Staff recruitment

The staff team consisted of one dentist and a trainee dental nurse who also performed reception duties.

Are services safe?

The dentist had current registration with the General Dental Council-the dental professionals' regulatory body. We saw evidence that the dental nurse was on an appropriate dental nurse course.

The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.These checks included for example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references. We reviewed both staffs' recruitment records and saw they were up to date with relevant information that would have been required at the time of their recruitment.

We saw that the dentist and trainee dental nurse had undergone appropriate checks from the Disclosure and Baring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had a health and safety guidance document which they referred to, to monitor health and safety.

The practice carried out various risk assessments to monitor health and safety. General risk assessments were carried out and specific ones completed as and when necessary. The general risk assessment had been updated on the 15 August 2016.

There was a fire risk assessment which had been completed on 15 August 2016. The assessment highlighted areas of improvements and had an associated action plan. The risk assessment was completed on an annual basis. Smoke alarms were tested every week and records were maintained. Fire extinguishers were checked monthly.

The fire evacuation plan was displayed in the surgery and the patient waiting area.

Infection control

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

There was a separate decontamination room with a clear end to end flow of "dirty" to "clean" instruments.

Decontamination of dental instruments was carried out both by the dentist and the trainee dental nurse. Instruments were manually scrubbed then sterilised in an autoclave.

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

Our checks showed that single use items such as rose head burs were being re-used. We discussed this with the principal dentist and they stated they were unaware that they were single use items. The principal dentist assured us they would ensure processes were tightened up to prevent this in the future.

We also found that clinical waste was not being disposed of in a safe way and in accordance with guidance. For example amalgam was being disposed of down one of the sinks in the decontamination room. (Amalgam is a combination of metals including mercury that is used in dentistry for fillings). The dentist confirmed that this process was going to stop immediately and they would follow proper procedures for disposal of clinical waste.

The logs from the autoclaves provided evidence that daily and weekly checks and tests were being carried out.

Staff were immunised against blood borne viruses and we saw evidence of when they had received their vaccinations. The practice had blood spillage and mercury spillage kits. Clinical waste bins were assembled and labelled in the surgery and decontamination room. Clinical waste was stored in an unlocked cupboard in the patient waiting/ reception area. The dentist advised us that they would arrange for a lock to be put on the cupboard to make it more secure. Clinical waste was collected monthly by an external company.

Are services safe?

There were appropriate stocks of personal protective equipment such as gloves and disposable aprons for both staff and patients. There were enough cleaning materials for the practice.

The surgery was visibly clean and tidy. We were told the trainee dental nurse was responsible for cleaning all surfaces and the dental chair in the surgery in-between patients and at the beginning and end of each session of the practice in the mornings/ evenings. We observed all areas of the practice to be clean and tidy on the day of our inspection.

The practice had an external Legionella risk assessment carried out in October 2016. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. No actions had been identified. Taps were flushed daily in line with recommendations and water temperatures were monitored monthly.

Equipment and medicines

The practice had portable appliances and carried out PAT (portable appliance testing) every three years. Appliances were last tested in August 2013 and August 2016.There was a contract in place for the servicing of equipment. The autoclave and pressure vessel were inspected and serviced on 3 October 2016. The ultrasonic bath had been tested on the 27 June 2016. We saw evidence of other electrical items being serviced and repaired appropriately such as portable appliance testing and gas safety.

The practice was carrying out dental procedures using conscious sedation (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). They advised us that they performed sedation infrequently; approximately 8-10 times a year.

The practice was not meeting the standards set out in the guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry, Department of Health 2003. The principal dentist was not aware of the updated guidance issued in 2015 and, did not have a forward plan in place to achieve the standards outlined in the 2015 guidance.

The trainee dental nurse was assisting with sedation and had not been appropriately trained. The dentist also had not received updated training for over 10 years. The principal dentist advised us that they were going to stop carrying out sedation until training had been completed and appropriate staff employed (i.e. a qualified dental nurse). The provider contacted us shortly following the inspection to confirm they had stopped providing dental procedures under conscious sedation and removed it as a service from their website.

Radiography (X-rays)

The trainee dental nurse was the radiation protection supervisor (RPS) and had completed relevant radiography training. The dentist had also completed Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 (IRMER) training in line with their CPD requirements.

The practice had an external radiation protection adviser (RPA).

Critical examination testing had been completed in 2013; however the practice was unable to evidence regular servicing of the X-ray equipment. We did see evidence that equipment was due to be serviced in November 2016.

The dentist was conducting annual audits of X-rays. The dentist also advised us that going forward they would ensure that justification and grading for X-rays was suitably recorded.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist described to us how they carried out their assessment of patients for routine care. This included the patient being asked to complete a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. A treatment plan was then given to the patient which included the cost involved.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

Preventive advice included tooth brushing techniques and dietary advice was being given to patients. Smoking and alcohol advice was also given to patients where appropriate. This was in line with the Department of Health guidelines 'Delivering Better Oral Health'. (Delivering better oral health is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Dental care records we observed demonstrated that the dentist had given oral health advice to patients.

A range of dental hygiene products to maintain healthy teeth and gums were available for patients; these were available in the reception area. Underpinning this was a range of leaflets available to patients explaining how patients could maintain good oral health.

Staffing

The practice staffing included one dentist and one trainee dental nurse. The dentist had current registration with their professional body, the General Dental Council. We saw example of them working towards their continuing professional development requirements, working through their five year cycle. [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 hours every five years].

We saw evidence that the trainee dental nurse was enrolled on an appropriate dental nursing course.

The practice had not reviewed staff training requirements in conscious sedation as set out in The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015. The trainee nurse assisting with conscious sedation had not completed any training and the dentist had not updated their training in many years. The dentist agreed that training was required as a matter of urgency and that they would refrain from undertaking dental procedures under conscious sedation until staff had completed appropriate training.

Working with other services

The practice had processes in place for effective working with other services. There was a standard template for referrals such as orthodontists and the hospital. Information relating to patients' relevant personal details, referring dental professional, reason for referral and medical history was contained in the referral. Copies of all referrals made were kept on the patients' dental care records.

The practice worked closely with neighbouring dental practices. Arrangements were in place for the practice to refer patients with mobility problems to a practice that was fully accessible and also for the practice to see patients in emergency situations is the practice was closed.

Consent to care and treatment

We spoke with the principal dentist about how they implemented the principles of informed consent. The dentist had a very clear understanding of consent issues and also told us they referred to the organisations consent policy.

All staff demonstrated sufficient knowledge of understanding of Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005, including the best interest principle. [The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care

Are services effective?

(for example, treatment is effective)

professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them]. Both staff had completed recent mental capacity Act training.

Dental care records we checked demonstrated that consent was obtained and recorded appropriately.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

There was one treatment room which was located away from the patient waiting area. Conversations between patients and dentists could not be heard from outside the treatment room which protected patient's privacy.

The patient waiting area and reception was very spacious and patient treatments were spaced out in a way that it was rare for more than one patient to be on the premises at any given time, so there was little risk of people overhearing conversations. The main entrance door required buzzer access and people could not enter without speaking with a member of staff through an intercom.

Staff were caring and empathetic. For example, staff told us that there was a designated space upstairs in the practice where patients could have consultations with the dentist in a non-clinical environment. This sometimes helped to ease patients' anxieties.

Dental care records were stored in paper form in a locked cabinet. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 33 completed CQC patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the service and quality of care they received was excellent and good. We observed that reception staff was polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The patient feedback we received confirmed that patients felt involved in their treatment planning and received enough information about their treatment. Patients commented that things were explained well, staff listened to their concerns, and they were provided with treatment options with the dentist outlining the best option in their opinion. Patients said they were given time to consider options and could arrange treatment at times that suited them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an equality and diversity policy. The policy outlined the steps they took to ensure people were treated equally and their diverse needs responded to. Staff gave us various examples of how they responded to patient's needs. For example, staff supported patients, and provided help where needed to complete medical history forms.

If a patient had a dental emergency they were asked to attend the surgery and would be seen as soon as possible. If it was a day when the dentist was not working, they were referred to another practice close by.

Tackling inequity and promoting equality

The local population was diverse with a mix of patients from various cultures and background. The staff team was diverse and staff spoke different languages which included Twi, Hindi and Urdu.

The practice was set out over two levels with the surgery upstairs on the first floor. The building was not wheelchair accessible or accessible for people with restricted mobility. The practice had arrangements in place with other local surgeries if people with restricted mobility wanted to see a dentist.

Access to the service

The practice is open 9.00am to 6.0pm Monday to Friday; appointments are only available on Tuesday, Wednesday and Fridays between these times. Patients were able to access emergency care when the practice was closed. There was a recorded message on the answer machine with the dentist's telephone number for patients to contact him out of hours.

The practice booked all appointments one hour apart with 45 minutes consultations for patients. This meant that there was always a 15 minute gap between patients if the dentist overran. Due to this staff told us that waiting times were minimal because there was always a gap between patients.

Concerns & complaints

We were told there had not been any complaints made in the past 12 months. We reviewed the complaints policy and spoke with staff about the handling of complaints. Staff we spoke with had a good understanding of complaints and how to handle them in line with the organisation's policy.

Details of how to make a complaint were displayed in the patient waiting area. This included details of the organisations they could escalate their concerns to including the dental complaints service.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was responsible for the day to day running of the practice. The practice maintained a system of policies and procedures.

Dental care records were stored safe on the practice computer. Computers were password protected and only accessible to authorised staff.

Staff told us that audits completed over the last 12 months included audits on hand hygiene, radiography, dental care records and patient satisfaction. We reviewed the audits and saw that the aim of the audit was clearly outlined along with learning outcomes. For example, the disability access audit had action points of considering a hearing loop for people with hearing impairments and introduction of large print notices.

However, risks associated with undertaking dental procedures under conscious sedation, re-use of single-use instruments such as dental burs and disposal of dental waste had not been recognised and suitably mitigated.

Leadership, openness and transparency

Staff in the practice were clear about their lines of responsibilities. Leadership was clear with the principal dentist having a clear presence.

We discussed the duty of candour requirement in place on providers with the principal dentist and they demonstrated understanding of the requirement. They gave us explanations of how they ensured they were open and transparent with patients and staff. The explanations were in line with the expectations under the duty of candour.

Learning and improvement

The staff team was very small so general staff meetings were held every month, although the dentist and trainee dental nurse discussed issues on a daily basis.

Learning opportunities were available to staff and the practice was funding the trainee dental nurse's course.

Staff appraisals were carried out annually. We reviewed an appraisal carried out in December 2015 and saw that development issues were discussed as well as training needs.

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

The practice carried out patient satisfaction surveys periodically. Results were very positive. We saw that results of surveys were analysed and suggestions looked into. For example, patients recommended that the practice needed updating and we saw that the practice were looking into updating the flooring and general décor.

Staff were involved in decisions made about the practice and their feedback was sought regularly.

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 How the regulation was not being met: • The provider had not ensured that their audit and governance systems were effective. • The provider did not have systems to enable them to continually monitor risks, and to take appropriate action to mitigate risks, relating to the health, safety and welfare of patients and staff. Regulation 17 (1)