

Tooting Med Centre Ltd

Tooting Medical Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 December 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 service was providing safe care in accordance with relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Tooting Medical Centre is located in the London Borough of Merton. It provides various health services including dentistry to private fee paying patients to a mainly Polish population.

We previously inspected the practice on 11 March 2014 and asked the provider to make improvements regarding the systems to ensure X-ray equipment did not present any risks to patients and to ensure the quality assurance systems clearly identified serious risks to patients. We checked these areas at a further inspection carried out on 9 May 2014 and found the required improvements had been made.

We carried out this inspection in response to a number of complaints and concerns received through CQC Share Your Experience forms regarding the dental services provided at the medical centre. This inspection was a joined inspection carried out on a different day with CQC hospitals directorate.

The medical centre is open Monday to Friday from 9.00am-9.00pm and from 10.00am-9.00pm on Saturday and Sunday. The dental care facilities include three dental consultation rooms, a reception and waiting area, a decontamination room and a staff room. There is a small step to enter the premises and there is limited space for people who use a wheelchair or mobility aids.

We were not able to speak with patients during this inspection.

The provider has employed a person to manage the medical centre and they are the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Our key findings were:

- Patients were involved in their care and treatment planning so they could make informed decisions.
- There were processes in place to reduce and minimise the risk and spread of infection, although improvements were required.
- There was appropriate equipment and access to emergency drugs to enable the practice to respond to medical emergencies. Staff knew where this equipment was stored.
- There was appropriate, well-maintained equipment for staff to undertake their duties.
- The provider did not have effective systems to monitor and improve quality, as was evident from the lack of routine audits in key areas, such as radiography, infection prevention and control and dental care records.
- There was lack of clinical oversight and effective monitoring of staff training and their continuous professional development (CPD) in line with General Dental Council (GDC) requirements.

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

- Ensure the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff.
- Ensure audits of various aspects of the service, such as radiography, are undertaken at regular intervals to help improve the quality of service. The service should also check all audits have documented learning points where necessary and the resulting improvements can be demonstrated.

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 arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review 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'.
- Review the practice's waste handling protocols to 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 sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- 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 (IR(ME)R) 2000.
- Review the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 service was providing safe care in accordance with the relevant regulations.

There were processes to ensure equipment and materials were maintained and safe to use. Risk assessments were completed. The provider had developed policies for safeguarding which were kept under review. Staff records seen did not include certificates to confirm that all staff were trained to the appropriate level for child protection or that they had all completed training in adult safeguarding. The staff we spoke with were aware of their responsibilities as regards safeguarding of vulnerable adults and children. We did not see systems for the provider to receive safety alerts from external organisations. Dental instruments were decontaminated suitably, although improvements were required to ensure the whole process was in accordance with current national guidance. Medicines and equipment were available in the event of a medical emergency although not all the recommended medicines were held at the service.

Are services effective?

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

Patients were given relevant information to assist them in making informed decisions about their treatment and consent was appropriately obtained. We checked dental care records to confirm the findings. They were primarily written in Polish. We checked the dental care records that were written in English and noted that improvement could be made to ensure they followed current guidance. The dentist told us they gave patients information relating to health promotion including smoking cessation and maintaining good oral health. It was not clearly evidenced that clinical staff were meeting their requirement for continuing professional development.

Are services caring?

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

Staff told us how they ensured patient's privacy was maintained and how they responded to patients when they were in pain or distressed. The dentists used a range of written information, discussions and photographs and videos to help patients understand their treatment.

Are services responsive to people's needs?

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

Patients had access to information about the service on the practice website. Urgent on the day appointments were available during opening hours.

There were systems in place for patients to complain about the service if required. Information about how to make a complaint was readily available to patients. We saw complaints were dealt with in line with the service policy.

Are services well-led?

We found that this service 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).

There was a lack of governance arrangements for the effective management of the service and there was limited evidence of clinical oversight of the dental service. There was lack of effective monitoring of staff training and their continuous professional development (CPD) in line with General Dental Council (GDC) requirements.

Summary of findings

There was no system for staff to receive annual appraisals or regular individual support. Staff meetings were not held and records were not kept of discussions the manager had with staff to inform them of learning from incidents and complaints.

There was lack of effective systems to monitor and improve quality, as was evident from lack of routine audits in key areas, such as radiography, infection prevention and control and dental care records.

Tooting Medical Centre

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 took place on the 14 December 2015 and was undertaken by a CQC inspector and a dental specialist adviser. Prior to the inspection we reviewed information we hold about the service and information available on the provider's website.

The methods used to carry out this inspection included speaking with two dentists, one dental nurse and reception staff on the day of the inspection, reviewing documents and completed patient feedback forms and observations of cleaning and decontamination of used dental instruments.

We did not receive any information from stakeholders regarding this service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The service had an incidents and accident reporting procedure. All incidents and accidents were reported in the incident and accident books. There had been one accident in the past 12 months. Staff we spoke with were aware of reporting procedures and would report incidents to the manager.

The manager described the system for handling incidents that related to a patient that was in line with the duty of candour expectations. This included apologies being given and patients updated of changes to improve the service. [Duty of candour is a requirement 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].

There had not been any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013) incidents, within the past 12 months.

There was however no evidence to show how the service managed safety alerts and how these were shared with relevant staff.

Reliable safety systems and processes (including safeguarding)

The manager was the safeguarding lead. The service had policies and procedures in place for safeguarding adults and child protection. The manager told us that she was working to ensure all staff had completed safeguarding and child protection training but this remained in progress. Details of the local authority safeguarding teams were readily available to staff. Staff we spoke with demonstrated a basic understanding of safeguarding issues and said they would report concerns to the manager. However we were not able to speak with all dental staff due to their working hours and were not able to confirm their understanding of safeguarding.

One dentist told us they undertook a medical history including any medical conditions, regular medicines taken and a social history when new patients attended and these were checked and updated at each visit. During our

inspection we checked dental care records although they were in Polish and we were not able to confirm that medical histories were detailed and updated at subsequent visits.

We asked how the practice treated the use of instruments that were used during root canal treatment. They explained that these instruments were single patient use only. A dentist we spoke with explained that root canal treatment and other treatment where appropriate was carried out where practically possible using a rubber dam. We noted that there were rubber dam kits in each dental treatment room we observed. (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).

Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

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. The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice with one exception. The midazolam was not in the buccal liquid form but in the 5mg/1ml ampoule format. Oxygen and other related items such as manual breathing aids and portable suction were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The expiry dates of medicines, oxygen and equipment were monitored enabling the staff to replace out of date drugs and equipment promptly. We were told that all staff had training in basic life support during 2015; however not all training records were available for us to confirm this.

Staff recruitment

There was a full complement of staff. The team consisted of six full time dentists, two part time hygienists, one dental nurse, three trainee dental nurses and six receptionists. We saw confirmation of all clinical staffs' registration with the General Dental Council (GDC).

Are services safe?

The provider had suitable policies and procedures in place for staff recruitment which included requesting proof of identification, references, and proof of professional qualifications and registrations. All staff had a Disclosure and Barring Service check. We did not see all relevant staff had provided proof of their immunisation status. We reviewed staff recruitment files and found some of the required documentation in place for longer standing staff; for more recently recruited staff the various required checks had been suitably completed. Most references and evidence of staff qualifications was in Polish.

Monitoring health & safety and responding to risks

The service had a health and safety policy and had carried out some risk assessments to respond to safety issues. Health and safety policies were displayed at the service. The fire alarm was tested every week and serviced annually.

There was a business continuity plan which included details of how to respond to incidents including power failure and disruption to the water supply.

Infection control

Although there were systems in place to reduce the risk and spread of infection within the practice, there were deficiencies when judged against HTM 01 05 (national guidance for infection prevention control in dental practices'). The practice utilised a separate decontamination room for the processing of used dental instruments and equipment.

Although one of the dental nurses we spoke with had overall responsibility for infection control in the practice we were not assured that they had fully understood the protocols they were required to follow as per guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. We were also told that they only worked two days a week. They described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the treatment room environment following the treatment of a patient. We were shown how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was broadly in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor previously, although the follow up assessment was overdue. The report contained recommendations that the practice had followed up, however some of the checks such as measuring water temperatures had not been carried out by the practice since the summer of 2015.

We saw the three dental treatment rooms were visibly clean. Zoning demarking clean from dirty areas was apparent in the decontamination room. Hand washing facilities were available in each treatment room including wall mounted liquid soap and paper towels. Hand washing protocols were also on display.

The drawers in the treatment rooms and decontamination room were well stocked, clean and generally ordered and free from clutter. Instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff and patient use.

The dental nurse demonstrated the decontamination process to us, from taking the dirty instruments through to clean and ready for use again. The process followed a defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing as part of the initial cleaning process. The decontamination room had a double sink in place for this process although this arrangement meant that there was no separate sink for handwashing purposes. We found that the temperature of the water used for manual scrubbing of used dental instruments was not being monitored to test if it was below 45 degrees Celsius.

Instruments were not inspected with an illuminated magnifier instruments to check the efficacy of the cleaning process before the instruments were placed in an autoclave (a machine used to sterilise instruments) in accordance with current guidance. We noted however that although the practice was not using the illuminated magnifier for inspecting manually scrubbed instruments, all of the pouched instruments we looked at did not show

Are services safe?

any evidence of remnants of any debris from the manual scrubbing process. When instruments had been sterilized they were pouched until required. Most pouches were dated with the date of sterilisation but we did find pouches that were not dated.

The nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the automatic control test. We observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

Though the segregation of waste was in line with current guidelines laid down by the Department of Health there were deficiencies with storage of the clinical waste prior to collection by the waste collection contractor. Although the waste was stored securely away from public access, the storage area was not suitable. The area although partially covered, was not sufficient to protect clinical waste bags and sharps bins from the elements and wildlife. We noted that the clinical waste bags and sharps bins were wet from recent rainfall. Although we were told that the waste was collected weekly on Thursday's, on the day of our visit (Monday) there were many bags waiting for collection which did not correlate with what we were told.

We spoke with staff about the management of safer sharps. The systems and processes we observed did not completely align with the current EU Directive on the use of safer sharps. The practice did not have a safer sharps risk assessment in place in accordance with current guidelines as part of the infection control policy that we were shown. We found that sharps bins were not overfilled but we did find sharps bins in two of the dental treatment rooms sited on the floor which presented a health and safety risk. The registered manager repositioned these sharps bins to a more suitable position after this was pointed out. We did see displayed at various points in the practice a protocol that would be followed should a needle stick injury occur. The practice did not use any devices protecting staff from inoculation injuries during the resheathing of used dental needles following the administration of a local anaesthetic. Although a nurse we spoke with indicated that the dentist used a scoop method for resheathing the used needle, we were not assured that this was standard practice carried

out by all of the dentists working in the practice. We saw one accident had involved a sharps injury and the policy had been used although the member of staff had not had blood tests completed.

We found that the practice did not undertake regular infection prevention and control audits in accordance with current guidance.

Equipment and medicines

Records we viewed reflected that equipment in use at the centre was regularly maintained and serviced in line with manufacturers' guidelines. We observed the maintenance schedules ensuring that the autoclave were maintained to the standards set out in the Pressure Systems Safety Regulations 2000. The autoclave was new and was under the manufacturer's warranty arrangements. A specialist company attended at regular intervals to calibrate the X-ray set to ensure it was operating safely. The most recent report was dated April 2014 which was in accordance with inspection interval of three years as recommended under the Ionising Radiation Regulations 1999. We also observed that a portable appliance test (PAT) had been carried out in accordance with current guidelines. PAT is the name of a process during which electrical appliances are routinely checked for safety. We did find that when medicines were dispensed from within the practice that there was a system in place which demonstrated some form of stock control which accounted for the medicines prescribed. The clinical entries of one dentist did give details of the local anaesthetics administered along with the batch number and expiry dates.

Radiography (X-rays)

The practice maintained a radiation protection file in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Adviser and a Radiation Protection Supervisor. Also included in the file were the critical examination pack and acceptance test for the X-ray set used along with the three yearly maintenance log and a copy of the local rules and notification to the Health and Safety Executive. The maintenance log was within the current recommended interval of three years. The next service was due in April 2017.

The practice was not carrying out audit of the quality of the radiographs taken. Current guidelines by the National

Are services safe?

Radiological Protection Board state that this should be carried out every 12 months. However, examples of X-rays we saw demonstrated that good quality was being maintained. We checked dental care records to confirm the findings and found that where X-rays had been taken the

dental X-rays were justified, reported on and quality assured every time. We however, also found from the dental care records we checked that the dentists were not recording the justification and subsequent report for each X-ray taken in accordance with IRMER regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We saw evidence of very good treatment outcomes from one dentist by observing intra oral photographs of treatment stages and post-operative X-rays taken following root canal treatment.

However, as most of the clinical entries in the dental treatment records were written in Polish we were not able to assure ourselves that the dentists were carrying out consultations and assessments in line with recognised general professional guidelines such as those outlined by the Faculty of General Dental Practice.

Although we were told that patients completed a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered the evidence was not clear from the computerised or hand written records that this was carried out.

Again as the entries in the care records were mainly Polish it was not apparent that the dental care records contained details of the conditions of the gums and soft tissues and that the findings of the assessment and details of the treatment carried out were recorded appropriately. It was also not clear from the records that where relevant, preventative dental information was given in order to improve the outcome for the patient was given. This included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures such as brushing techniques or recommended tooth care products.

Health promotion & prevention

The service employed two part time dental hygienists. However, it was not clear from the records we saw that patients attending the practice were advised during their consultation of steps to take to maintain healthy teeth.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council. We saw some evidence of clinical staff being up to date with their continuing professional development (CPD) 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 every five years) although this was not clear for all clinical staff. There was no oversight of staff training and the expectation was for staff to sort out their own training although here were no systems to ensure the service was updated. There was no evidence of systems for staff meetings or individual support and development meetings.

We reviewed staff files and saw staff had the relevant qualifications and had completed some of the appropriate training to enable them to provide treatment and care to patients. Staff we spoke with confirmed they had access to the training and support they needed to carry out their role.

Working with other services

The service had a system in place showing how they worked with other services. The dentist were able to refer patients to a range of specialists in secondary and tertiary care services if the treatment required was not provided by the service.

Consent to care and treatment

A dentist we spoke with had an understanding of consent issues. Although the service used consent forms as part of the consent process we were not fully assured that, the consent process was completed in full. This was because most of the clinical entries in the dental treatment records were written in Polish. We saw a copy of the consent form translated into English and were told the dentists would speak with patients in a mix of English and Polish, depending on the patient's preference.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff told us that they maintained patients' privacy and dignity during consultations by closing doors of the treatment rooms. The dental nurses told us they tried to offer emergency appointments for patients who were experiencing pain. During our inspection we observed staff being respectful by ensuring that the consultation room door was always closed and conversations could not be overheard.

We observed staff interaction with patients in the waiting room and saw that reception staff spoke with patients in a respectful manner.

Patients' information was held securely electronically and computers were password protected with individual login requirements.

Involvement in decisions about care and treatment

Because the dental care records were mainly written in Polish we were not assured that patients were adequately informed about their care and treatment. This included costs of the various treatment procedures. However the practice website contained a comprehensive list of the costs of dental treatment. The manager told us the dentists used patient information leaflets to help patients understand the process before they underwent procedures including removal of a wisdom tooth and dental implants. The dentists had access to intra oral cameras to help them discuss treatments with patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We discussed with staff how the service responded to the needs of their patients.

Emergency appointments were available and the service aimed to see patients when they were in pain and needed an urgent appointment.

Tackling inequity and promoting equality

The patient population was predominantly Polish and staff at the practice spoke Polish and were able to speak with patients.

The building was set over three floors although only the ground floor was used by dentists and dental patients. There was a small reception and waiting area which could accommodate a pushchair if required. Consultation rooms were on the ground floor and were accessible to people who used a wheel chair although they were small and transferring from a wheelchair to the dental treatment chair might be difficult.

Access to the service

The service had website with information about the medical centre, treatments provided, payment options, opening times and contact details.

Appointments were booked by calling the service, in person by attending the practice and through the service website.

Staff told us that appointments generally ran to time and if the dentist was running behind time they would let patients know.

Concerns & complaints

The provider had a complaints policy and procedure in place which included receiving, handling and resolving complaints. Details about how to make a complaint were displayed in the waiting area and on the practice website.

At the time of our visit there had been three complaints in the past 12 months. The manager went through the complaints with us; their explanations and records showed the actions taken were in line with their policy. The manager told us learning from the complaints would be shared with relevant staff.

Are services well-led?

Our findings

Governance arrangements

There was lack of effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. For example, there was no programme of audits in place and we did not see any completed audits or any evidence of improvements to the services through the use of audits. We noted that audits such as those for infection prevention and control, suitability of X-rays and completeness of dental care records had not been undertaken.

The practice had a range of policies to ensure the operation of the service. These were kept under review. However, records of staff induction processes did not confirm staff had read and understood the policies.

Leadership, openness and transparency

The service aim was to provide gentle dentistry in a relaxed and friendly environment and to promote good dental health and preventative care. While staff we spoke with were not always clear about this aim, they wanted to provide appropriate treatment to patients. They were positive about their experience working at the medical centre saying they were happy to be working there.

We discussed the duty of candour requirement in place on providers and the manager demonstrated their understanding of this 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.

(Duty of candour is a requirement 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).

Learning and improvement

Leadership in the service was clear although there was a lack of clinical oversight of the dental service. There were limited opportunities for dental staff to meet and receive support. Staff were expected to identify and meet their training needs and there was no evidence of how the provider ensured dental staff followed relevant codes of practice. The manager could view the training staff had completed using the electronic system the provider used. However, there was no process to ensure staff updated the provider with face to face training they had completed.

Meetings were not held and the process for keeping dental staff informed of issues and learning from complaints and incidents was adhoc and not recorded. Arrangements were not in place for dental staff to have annual appraisals.

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

The service used a range of social media and their own patient satisfaction surveys to seek patient's opinions of the dental service. The manager gave patients surveys on a monthly basis and reviewed the comments received. Any negative comments were followed up. We reviewed the results of recently completed forms and saw they were positive regarding reception staff, information given and dental treatment received and patients confirmed they would recommend the service to their friends and family.

Staff we spoke with confirmed they would speak with the manager regarding issues and concerns and with any ideas for the service.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider did not have effective systems in place to :</p> <ul style="list-style-type: none">• Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.• Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.• Ensure that their audit and governance systems remain effective. <p>Regulation 17 (1) (2) (a) (b) (f).</p>