Mr. James Alan Clarke

Mr James Alan Clarke - Rowlandson Terrace

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 July 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

The practice is a small family run part-time service. There is one dentist and one dental nurse who also undertakes reception duties.

The practice provides general dental services and to about 400 private patients.

The practice is open Monday, Tuesday and Thursday 9am to 5pm.

The dentist is the registered provider for the practice. 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 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.

We reviewed three comment cards on which patients provided feedback about the service. All the comments were positive about the staff and the services provided. Patients commented that the practice was clean, they found staff friendly and the treatment was excellent.

Our key findings were:

- The practice recorded complaints and cascaded learning to staff.
- Staff had received safeguarding training, knew how to recognise signs of abuse and how to report it.

Summary of findings

- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to manage medical emergencies.
- Patients received clear explanations about their proposed treatment, costs benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs.
- The practice sought feedback from staff and patients about the services they provided.
- Infection control procedures were in place in accordance with the published guidelines but not all procedures had been followed.
- The governance systems were not effective in all areas.

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

- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and others who may be at risk which arise from the carrying on of the regulated activity.
- Maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided.

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

- Ensure the practice complaints procedure is displayed in accordance with General Dental Council (GDC) document 'Standards for the dental team'.
- Ensure that their policies and procedures are regularly updated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Staff had received training in safeguarding and knew how to recognise the signs of abuse and how to report them. Staff had also received training in infection control. There was also a decontamination room and guidance for staff on effective decontamination of dental instruments.

Staff were appropriately recruited and suitably trained and skilled to meet patients' needs and there were sufficient numbers of staff available at all times.

The practice had no record of any significant events having taken place.

The practice did not always have effective systems and processes in place to ensure that all care and treatment was carried out safely. For example, there were systems in place for infection control, however, not all recommendations in the last legionella report or the guidance issued by the Department of Health had been followed.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE).

On joining the practice, patients underwent an assessment of their oral health and were asked to provide a medical history. This information was used to plan patient care and treatment. Patients were offered options of treatments available and were advised of the associated risks and benefits. Patients were provided with a written treatment plan which detailed the treatments considered and agreed together with the fees involved.

Patients were referred to other specialist services in a timely manner.

Staff were registered with the General Dental Council (GDC) and maintained their registration by completing the required number of hours undertaking continuing professional development (CPD) activities.

Are services caring?

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

The CQC comment cards we reviewed reflected that patients described the service as excellent, very caring and that they were treated with dignity and respect.

There were separate reception and waiting areas which helped to make it less likely that conversations between staff and patients would be overheard by others.

Are services responsive to people's needs?

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

Patients could access treatment and urgent care when required. The practice offered appointments on the day for patients experiencing dental pain which enabled them to receive treatment quickly.

Summary of findings

The practice had a complaints leaflet which was available to any patients who wished to make a complaint. The process described the timescales involved for dealing with a complaint and who was responsible for handling complaints. However, the leaflet was not freely available to patients; they needed to ask for a copy if they needed it.

Are services well-led?

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 section at the end of this report).

Staff were supported through training and offered opportunities for development.

Staff reported that the dentist was approachable and they felt supported in their roles and were freely able to raise any issues or concerns with them at any time. The culture within the practice was seen as open and transparent. Staff told us that they enjoyed working at the practice.

The practice regularly sought feedback from patients in order to improve the quality of the service provided.

The practice held regular staff meetings which were minuted and gave staff an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions.

The registered provider did not ensure that their governance policies and procedures were regularly updated to ensure that they remained current. For example, there was no evidence that the Control of Substances Hazardous to Health (COSHH) folder had been kept up-to-date.

Not all patients' clinical records were complete.

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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 registered provider was meeting their obligations associated with the Health and Social Care Act 2008.

The inspection was carried out on 8 July 2015 and was led by a CQC inspector who was supported by a dentist specialist advisor.

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.

We reviewed information received from the registered provider prior to the inspection.

The methods that were used to collect information at the inspection included interviewing staff, observations and review of documents.

During the inspection we spoke with the registered provider the dentist, a dental nurse who was also the receptionist. We reviewed policies and procedures, five clinical patient records and other records relating to the management of the service. We reviewed 22 CQC comment cards that had been completed.

Are services safe?

Our findings

Reporting, learning and improvement from incidents
The practice had policies and procedures in place to investigate, respond to and learn from significant events and complaints. The dental nurse was aware of the reporting procedures in place and encouraged to raise safety issues with the registered provider. Staff understood the process for accident and incident reporting including their responsibilities under the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We saw that the practice had an accident book to record accidents. There were no entries at the date of the inspection.

The registered provider told us that they received alerts by email from the Medicines and Healthcare products Regulatory Agency (MHRA), the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness. Relevant alerts were discussed with staff, actioned and stored for future reference.

Reliable safety systems and processes (including safeguarding)
We reviewed the practice's safeguarding policy and procedures in place for child protection and safeguarding vulnerable adults using the service. They included the contact details for the local authority safeguarding team, social services and other relevant agencies. The registered provider was the lead for safeguarding. We saw that all staff had received safeguarding training. Staff could easily access the safeguarding policy. Staff we spoke with demonstrated their awareness of the signs and symptoms of abuse and neglect. They were also aware of the procedures they needed to follow to address safeguarding concerns.

The dentist told us that they did not routinely used a rubber dam when providing root canal treatment to patients. A rubber dam is a small rectangular sheet of latex (or other similar material if a patient is latex sensitive) used to isolate the tooth operating field to increase the efficacy of the treatment and protect the patient. We discussed this with the registered provider and explained that it is good practice to use a rubber dam.

Medical emergencies
The practice had procedures in place for staff to follow in the event of a medical emergency. We saw that the dentist and the dental nurse had received training in basic life support in April 2015. The practice kept medicines and equipment for use in a medical emergency. This was in line with the 'Resuscitation Council UK' and British National Formulary guidelines. However, it did not include all the equipment recommended. For example, the practice had adult face masks but lacked any child face masks for children for attaching to the self-inflating bag. In addition there was no automated blood glucose measurement device.The dental nurse was responsible for regularly checking that the medicines were within the manufacturer's expiry dates. The medicines and the emergency oxygen were checked monthly. We saw records of this which indicated that the checks had been undertaken since 2013. We discussed this with the dentist and dental nurse and reminded them that the checks needed to be on a weekly basis. The dentist and the dental nurse agreed to undertake weekly checks in future.

Staff recruitment
The practice had a recruitment policy which included a process to be followed when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with relevant professional bodies and taking up references. We saw from a review of a dental nurse's personnel file that it included this information except for a reference. We spoke to the registered provider about this and they told us that they had taken up verbal references, but had not recorded this.

We saw that the dentist and the dental nurse been had been checked by the Disclosure and Barring Service (DBS). The DBS checks 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.

We saw that the registered provider had personal indemnity insurance (insurance professionals are required to have in place to cover their working practice) which was due for renewal in December 2015. The policy also included personal indemnity for the dental nurse. In addition, there was employer's liability insurance which covered employees working at the practice which was due for renewal in January 2016.

Are services safe?

Monitoring health & safety and responding to risks

The practice had undertaken a number of risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice. We viewed a range of these including the fire risk assessment. We saw that the last fire risk assessment had taken place five years ago; we discussed this with the registered provider. The registered provider had maintained a Control of Substances Hazardous to Health (COSHH) folder. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. We saw from the COSHH folder that it had not been regularly reviewed to ensure that it remained up to date. We discussed this with the dentist and dental nurse and they agreed to review and update the information as necessary.

Infection control

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05),Decontamination in primary care dental practices. The dental nurse was aware of the work flow in the decontamination room from the 'dirty' to the 'clean' areas. The room had an extractor fan to aid good air flow to reduce the risk of cross contamination. There was a separate hand washing sink in addition to two additional sinks for decontamination work. The procedure for cleaning, disinfecting and sterilising the instruments was displayed. Personal protective equipment was available except for heavy duty rubber gloves. The dental nurse told us that they did not wear an apron, mask or eye protection when decontaminating instruments; they only used clinical rubber gloves. We raised our concerns about this with the registered provider and dental nurse who indicated that they thought this was not a problem.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM01-05). The dental nurse spoke knowledgeably about the decontamination process. However, they did not demonstrate that they followed the correct procedures. For example, instruments were routinely visually examined but not routinely examined, visually with a magnifying glass which was available. Sterilised instruments were correctly packaged, sealed, stored and dated with an expiry date.

We saw records which showed that the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of the decontamination cycles of the autoclave to ensure that it was functioning properly.

Instruments were transported between the decontamination room and the surgeries in sterile containers.

The registered provider and the nurse were aware of the designated 'clean and 'dirty' areas within the surgeries. However, these zones were not clearly defined to avoid the likelihood of confusion or errors. We discussed the zoning with the registered provider. The registered provider told us that they had risk assessed this and decided as they were the only people who would use the surgeries there was no need to make any changes. We were also told that there was no written record of this assessment having taken place.

We asked to see the result of the latest infection control audit. The registered provider told us that they have never undertaken an infection control audit and the guidance in HTM 01-05 only related to dental practices who provided treatment under the NHS. We explained that was incorrect and they needed to undertake infection control audits every six months as detailed in HTM 01-05. As such the registered provider was not compliant with their obligations under HTM01-05 in respect of auditing their decontamination processes.

There were adequate supplies of liquid soap and paper hand towels in the decontamination room and surgery, and posters describing proper washing techniques was located inside cupboards. Paper hand towels and liquid soap was also available in the toilet. We saw that the sharps bin was being used correctly. However, the one in the ground floor surgery was located on the floor which is not recommended because it was potentially accessible to children. The registered provider agreed to relocate the sharps bin to suitable location. Clinical waste was stored securely for collection. The provider had a contract with an authorised contractor for the collection and safe disposal of clinical waste.

Are services safe?

The staff files we reviewed showed that they had received inoculations against Hepatitis B. It is recommended that people who are likely to come into contract with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections.

We saw records which showed that the practice undertook weekly biofilm treatments of their dental water lines to ensure they were safe.

We reviewed the legionella risk assessment which was dated March 2011; it recommended the removal and replacement of a water tank. This recommendation was followed. Legionella is a term for particular bacteria which can contaminate water systems in buildings. The assessment was due to be reviewed but this had not taken place. In addition, regular water temperature monitoring in accordance with the legionella risk assessment report had not taken place. We discussed this with the registered provider who told us they were confused as to who was responsible for ensuring those recommendations were followed. We showed them the relevant page in the report where it stated that they were responsible. The registered provider told us that they would monitor the water temperatures in future and told us they would either review the risk assessment or arrange for a new legionella risk assessment to take place.

Equipment and medicines

Records we reviewed demonstrated that Portable Appliance Testing (PAT) took place in June 2015. (Portable Appliance Testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.) We discussed this with the registered provider. They told us that they had planned the testing to take place every three years. The practice had mains operated smoke alarms, fire exit signage and fire extinguishers. We saw that the fire extinguishers had been recorded as having been checked regularly until July 2011. We discussed this with the registered provider who advised that they paid for the fire extinguishers to be checked annually and they were scheduled to be checked in August 2015.

We saw maintenance records for equipment such as autoclaves and X-ray equipment. For example, the autoclave and the washer disinfector were serviced in June 2015 and the compressor was serviced in July 2015. The regular maintenance ensured that the equipment remained fit for purpose.

Local anaesthetics were stored in a lock cupboard in the main surgery.

Radiography (X-rays)

The X-ray equipment was located in the surgeries and X-rays were carried out safely and in line with the rules relevant to the practice and type and model of equipment being used.

We reviewed the practice's radiation protection file. This contained a copy of the local rules which stated how the X-ray machine needed to be operated safely. It also contained the name and contact details of the Radiation Protection Advisor. We saw that the registered provider was up to date with their continuing professional development training in respect of dental radiography. There was also a performance report dated January 2014 which showed that the X-ray equipment was not operating correctly. The records also showed that problem was rectified in February 2014. It is scheduled to be tested again in January 2017.

The registered provider told us that they graded X-rays when they took them but have not formally audited them for five or six years. They also told us that they took X-rays according to individual need. For example, if patients had a problem such as dental pain, or needed endodontic treatment or routinely every four years. We reminded them that this was not in accordance with guidance from the Faculty of General Dental Practice (FGDP).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

New patients to the practice were asked to complete a medical history form which included health conditions, current medicines and allergies prior to their consultation and examination of their oral health with the dentist. The practice recorded the medical history information on the patients' electronic dental records for future reference. In addition, the dentist told us that they discussed patients' smoking and drinking practices and where appropriate offered them health promotion advice. For example, the dentist told us that they gave new mothers information and instruction in oral hygiene and health care advice. We saw from the five dental records we reviewed that patients were always asked to review their medical history each time they attended. This ensured the dentist was aware of the patient's present medical condition before offering or undertaking any treatment. All of the records showed that routine dental examinations included checks for gum disease and oral cancer. They also recorded the justification and the quality of the X-rays taken.

The dentist told us that they always discussed the diagnosis with the patient and, where appropriate, offered the patient any options available for treatment and explained the costs. Comments on the CQC comment cards reflected this.

The registered provider told us that their patients' oral health was monitored through follow-up appointments and these were scheduled for every six months in line with the practice's private dental scheme. In addition patients would be seen sooner if in their judgement there was a need to ensure good oral health.

Patients requiring specialist treatments that were not available at the practice such as conscious sedation or orthodontics were referred to other dental specialists. Their oral health was then monitored at the practice after the patient had been referred back to the practice. This helped ensure patients had the necessary post-procedure care and satisfactory outcomes.

We reviewed five electronic patient records. They were clear but some were incomplete. For example, all records recorded patients' medical histories but not consent. Within those records there were no records of treatment options having been discussed or that written treatment plans had been offered or costs explained. All records showed that a basic periodontal examination (BPE) – a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums, had taken place. However, fully charted results of the examinations were not present in the records. We discussed the need for better record keeping with registered provider.

Health promotion & prevention

The waiting areas contained a range of information that explained the services offered at the practice and the private fees for treatment in addition to information about effective dental hygiene and oral care.

The registered provider told us that they gave oral health advice. For example, they asked patients about smoking and alcohol consumption and advised them on the effects if relevant.

Staffing

We saw that the staff were currently registered with their professional body, the General Dental Council. We saw that staff were maintaining their continuing professional development (CPD) training to update and enhance their skill levels. Completing a prescribed number of hours of CPD training is a compulsory requirement of registration as a dental professional.

Training was being monitored and recorded. Records we reviewed showed that the registered provider and dental nurse had received training in basic life support, infection control and safeguarding children and vulnerable adults.

Working with other services

The dentist explained that they would refer patients to other dental specialists when necessary. They would refer patients for sedation, oral surgery and orthodontic treatment when required. The referrals were based on the patient's clinical need. We saw from the records that patients were referred in a timely way. Referral correspondence was stored electronically with patients' records.

Consent to care and treatment

The registered provider and the dental nurse were aware of the Mental Capacity Act 2005 (MCA).The registered provider told us that they had a small group of loyal patients none of whom had any problems in communicating with them about their care or treatment. If circumstances changed

Are services effective?

(for example, treatment is effective)

and concerns arose about a patient's capacity to give consent they would seek guidance to ensure they complied with the requirements of the MCA before offering and undertaking any treatment.

The registered provider ensured patients gave their consent before treatment began. The registered provider informed that verbal consent was always given prior to any treatment. Patients were given time to consider and make informed decisions about which option they preferred. The registered provider was aware that consent could be removed at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy
The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. The dental nurse/receptionist told us that they were able to have confidential conversations with their patient in the surgeries and at reception. The reception and waiting room were separate.

Staff we spoke with understood the need to maintain patient confidentiality. The dentist was the lead for information governance with the responsibility to ensure patient confidentiality was maintained and patient information was stored securely. We saw that patient records, both paper and electronic were held securely.

People who completed the CQC comment cards described the service as excellent, very caring and treated with dignity and respect.

Involvement in decisions about care and treatment
The dentist and dental nurse explained that their patients had been with them for some time and felt that they had a good relationship with them. They also told us that they involved their patients in all decisions about their care and treatment. Comments made on the CQC comment cards reflected this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs
Information displayed in reception and the waiting room described the range of services offered to patients and opening times.

For patients in need of urgent dental care during normal working hours of the practice, for example those in pain, the practice operated an open access service for emergencies. Those patients were seen on the same day. If urgent treatment was required out of normal working hours patients were directed to the Dencall service who would re-direct them to a dental practice for treatment. The practice had a policy and processes to deal with complaints. The policy set out how complaints and concerns would be investigated and responded to. Information about complaints was displayed in the reception. The dental nurse explained that if a patient wished to make a complaint they needed to ask a member of staff for details. We explained that this was not in accordance with the General Dental Council (GDC) standards.

Tackling inequity and promoting equality
The reception, waiting area, toilet facilities and a surgery were located on the ground floor of the building with easy patient access for patients with mobility issues. The dental nurse told us that patients were offered treatment on the basis of clinical need and did not discriminate when offering their services.

Access to the service
Patients could access the service in a timely way by making their appointment either in person or over the telephone.

The practice was open Monday, Tuesday and Thursday 9am to 5pm.

Some patients commented on the CQC comment cards that is was easy to make appointment with the practice.

The registered provider told us that they knew their patients well and had treated them and in some instances whole families for many years. Currently if either or both the dentist or the dental nurse was absent from the practice because of sickness or holidays they would cancel and re-book appointments. In addition, the practice had a reciprocal agreement with another local dental practice for them to see their patients if necessary. This ensured continuity of care for patients.

Concerns & complaints
The practice had a complaints policy which explained the practice would acknowledge a complaint within two days and provide a substantive response within 10 days. This is in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. There was a notice on display in the reception advising patients to ask a member of staff for details on how to make a complaint if needed. This is not in accordance with the General Dental Council (GDC) standards which state that dental practices should make sure that their complaints procedure is displayed where patients can see it and patients should not have to ask for a copy.

The dentist told us that they had never received any complaints.

Are services well-led?

Our findings

Governance arrangements
The registered provider was the lead for all areas of the practice and responsible for the day to day running of the practice. The dental nurse was aware of their roles and responsibilities within the practice.

The practice had governance arrangements in place such as various policies and procedures for monitoring and improving the services provided for patients. For example, there was a recruitment policy and an infection control policy.

The registered provider was aware of the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), Decontamination in primary care dental practices. One of the requirements of HTM 01-05 is for dental practices to undertake six monthly infection control audits. The registered provider confirmed that they had not undertaken any such audits and stated that they thought as a private practice they were exempt from the requirements of HTM 01-05.

The March 2011 legionella risk assessment was due to be reviewed but this had not taken place. The registered provider told us they were confused as to who was responsible for ensuring all the recommendations were followed. We showed them the relevant page in the report where it stated that they were responsible.

The registered provider told us that they monitored their X-rays when they took them rather than undertaking a formal auditing process. There was no evidence of recent clinical audits, for example, record keeping audits which would highlight any irregularities that may need addressing.

We saw from the Control of Substances Hazardous to Health (COSHH) folder that it had not been regularly reviewed to ensure that it remained up to date.

Leadership, openness and transparency
There was an open culture at the practice which encouraged candour and honesty. The registered provider and nurse worked as a team to provided care and treatment to their patients. The dental nurse told us that they felt able to raise any concerns with the registered provider and they were confident that any issues would be appropriately addressed.

Management lead through learning and improvement
We saw that the registered provider and dental nurse had maintained their CPD hours. The dental nurse stated they had sufficient training to undertake their role and had the opportunity for additional training. They also told us that they keep up to date by reading topics in dental journals.

Practice seeks and acts on feedback from its patients, the public and staff
The practice sought feedback from patients and staff. The practice provided a suggestion box which give patients an opportunity to give feedback anonymously. The dental nurse told us that they opened the suggestion box on a daily basis. They had received three suggestions two of which were complimentary and one was a request asking them not to use a particular piece of equipment in future.

The practice held regular staff meetings which were minuted and gave the registered provider and the dental nurse an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions.

The dental nurse told us that they always asked patients about the treatment they had received to give them an opportunity to comment and would address any issues as they arose.

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 practice did not have effective systems in place to; Maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided. 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. Regulation 17(1)(2)(b)(c)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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