Diamond-Garrott Ltd @ Belmont House Clinic

Inspection report

Belmont House Clinic
Gloucester Road, Patchway
Bristol
BS34 5BQ
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The service was registered with the Care Quality Commission (CQC) in July 2021 and this is the first inspection since registration.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Diamond-Garrott Ltd @ Belmont House as part of our planned inspection programme.

Diamond-Garrott Ltd is a private medical service located in the Bristol Area, situated in Belmont House. It provides consultation and diagnostic services and treatment for ophthalmic conditions such as glaucoma and cataracts under this registration. The services at this location included the use of a laser for diagnostic and minor treatment purposes, general ophthalmology including eye infections or discomfort. The service operated from a room within a shared building at Belmont House. Where the treatment required surgical intervention such as cataract surgery (involves replacing the cloudy lens inside your eye with an artificial one), intraocular lens for astigmatism (where the eye is shaped more like a rugby ball than a football) this would take place at a local hospital where the provider has practicing privileges. Therefore, we did not inspect or report on these services.

The service is led by a consultant ophthalmologist, who is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like 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 service is run.

As part of the inspection, we reviewed feedback provided to us through CQC "Feedback on care" forms.

Our key findings were:

- There were systems and processes in place but these were not always clear or embedded to keep patients safe.
- Oversight of recruitment and training was not monitored effectively or in line with service policies to ensure the quality and safety of services being provided.
- Patients received effective care and treatment that met their needs.
- Patients were treated with kindness and respect. They were involved in decisions about their care.
- Patients could access care and treatment in a timely way.
- The service promoted the delivery of quality, person centred care.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Overall summary

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure care and treatment is provided in a safe way to patients.

The areas where the provider **should** make improvements are:

- Record and review information from external sources including peers, stakeholder and regulatory bodies.

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Chief Inspector of Health Care

Our inspection team

Our inspection team was led by a CQC lead inspector who was supported by a CQC Nurse specialist advisor.

Background to Diamond-Garrott Ltd @ Belmont House Clinic

Diamond-Garrott Ltd

Belmont House Clinic

Gloucester Road

Patchway

Bristol

BS34 5BQ

This service registered with the Care Quality Commission (CQC) in July 2021. The services offered include consultation, diagnostic and minor treatments for ophthalmic conditions such as cataracts (an eye condition where the lens develops cloudy patches) and glaucoma (an eye condition where the optic nerve becomes damaged).

This service is registered with the CQC for providing the regulated activities of Treatment of disease, disorder or injury and Diagnostic and screening procedures. They are registered to provide care to adults (people aged over 18). They are treating on average 1-50 patients a month and approximately 300 patients per year.

The service is situated in a shared building, where the buildings management held responsibility for the cleaning arrangements and some of the premises risk assessments, for example, buildings and fire risk assessments, legionnaires servicing and some infection prevention and control audits.

The registered manager and lead clinician for the service employed a bank staff member to support the testing of patients' eyes on an occasional basis.

The service is open on Fridays between 8:30am and 5:30pm.

How we inspected this service

We gathered and reviewed information prior to and during the inspection which was obtained from the provider. We asked the provider to return a provider information pack (PIR) prior to the start of the inspection which we reviewed before the site visit. We spoke with the registered manager and reviewed patient feedback sent to us.

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.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

- The provider could not evidence staff had received immunisations in line with the green book national guidance.
- Staff training had not been monitored effectively.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider held safety risk assessments and sought assurances from the buildings management in which the service was situated. These included, premises and fire risk assessments.
- The service held a range of appropriate safety policies, however there were some overlapping policies and documents. For example, the provider held separate documents for safeguarding including, a 5-step process to report abuse, signs and symptoms, alert checklist and a vulnerable adults policy. Information was not always streamlined to be readily accessible.
- Staff received safety information from the service, however we found no evidence of a staff induction. We saw that the employed staff was required to show their competence annually on the equipment used.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider did not have evidence of all their or the staff members immunisation history in line with the Green book guidance. This had not been risk assessed. The Green Book has the latest information on vaccines and vaccination procedures, for preventable infectious diseases in the UK.
- The provider carried out staff checks at the time of recruitment. Disclosure and Barring Service (DBS) checks were available where required. (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). The service employed a bank technician who provided evidence of a DBS carried out by another service.
- The service had systems to safeguard children and vulnerable adults from abuse. The registered manager had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. The registered manager appropriately held level 3 safeguarding training. On the day of inspection, the service was unable to provide evidence of the employed staff member had completed safeguarding training. After the inspection, we were provided with evidence that they had completed level 1 training, which is not in line with intercollegiate guidance.
- The service did not provide any intimate examinations, however still offered a chaperone service. The provider had overlapping chaperone policies, which outlined chaperones should receive instruction on how to carry out the role. There was no evidence to show chaperoning training had been carried out for staff.
- There was a system to manage infection prevention and control (IPC). The provider has carried out a risk assessment in line with their policy and held appropriate IPC training. The provider had not requested the staff member complete IPC training in line with their infection control policy.
- The provider held a copy of the Legionella report that was last completed in 2023. This was completed on an annual basis by the buildings management and there had been no concerns found. Legionnaire's disease is a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria. All hot and cold water systems in the premises are a potential source for legionella bacteria growth.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. The provider did not use any sharps (needles) for the service they provided.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Requires Improvement

Are services safe?

- On the day of inspection, we found the provider carried out laser treatment in a consultation room. When in use they would place a notice on the door to avoid anyone walking in. However, there was no lock on the door to ensure the entry of a person, which could be affected by the laser. This had not been risk assessed. We raised this with the provider and after the inspection, we were sent evidence that a lock had been placed on the door and a risk assessment was in place to protect patients and staff.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. The service offered treatments which was managed by the registered manager, however when clinics were busier, the provider employed a bank staff member to support with testing of patients.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. There were emergency protocol algorithms available for staff to follow. They knew how to identify and manage patients with severe infections, for example sepsis. On inspection, we were unable to be provided with a policy for the management of medical emergencies and the provider did not have in date basic life support (BLS) training, which placed patients at risk for not receiving safe care and treatment. We raised this with the provider and after the inspection, we were provided with evidence that their emergency policy had been updated to reflect incident management and medical emergencies. The provider told us they had booked BLS training for the near future.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk assessment to inform this decision.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. We also found out of 5 patient files we reviewed, 1 was missing procedure documentation from their last visit. After the inspection, the registered manager told us that the missing documentation had been recovered and returned to the patient notes. The registered manager transports the relevant paper documents for their clinics as required. Patient notes are secured safely at an alternative premises.
- The provider did not routinely ask for patient's allergies alongside their medical history, but would do so if they were to prescribe a medicine. We raised this with the provider and they told us that allergies would be something they could include in the future.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. It was part of standard processes that the provider share their findings in a letter to the GP or other relevant healthcare professionals, with the patients consent.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- The provider was registered with the Information Commissioners Office (ICO). They held a policy on information governance that identified the senior clinician as the information governance lead. All staff had received information security and data protection training.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Requires Improvement

Are services safe?

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines and equipment minimised risks. The provider did not store any high-risk medicines.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- The service kept prescription stationery securely. The provider documented in patient notes where prescriptions were issued.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had not carried out any prescribing audits to make sure they were prescribing in line with guidance at the time of inspection.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. The provider sought assurances for risk assessments provided by the buildings management in relation to fire and premises risk assessments.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service. The service had not had any incidents in the last 12 months but provided an example of how they had recorded an earlier incident. This included:
  - The provider recorded the incident in line with their policy.
  - Identified changes that could be made and actioned these alongside the buildings management.
  - The service maintained contact with the patient to monitor recovery.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. There is a policy for responding to Medicines and Healthcare products Regulatory Agency (MHRA) alerts.

Good

Are services effective?

We rated effective as Good because:

The clinician assessed and delivered care and treatment in line with current legislation, standards and guidance.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed assess needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- The provider met with peers, who were available to discuss cases if needed.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. The provider had arrangements for patients to return on an annual or 6 monthly basis as required. They had contracted an external company to monitor this and would invite patients for an appointment within the recommended timescales.

Monitoring care and treatment

The service monitored activity for quality improvement.

- The service was not involved in any quality improvement initiatives. The provider monitored patient outcomes, patient feedback for areas of improvement in line with their vision and strategy.
- The service had completed audits including patient record notes and treatments. Audits of patient notes and complications showed no concerns and had not yet completed a second cycle due to low patient numbers.

Effective staffing

The registered manager had the skills, knowledge and experience to carry out their roles, however systems to support staff members were not always clear.

- All staff were appropriately qualified. On the day of inspection, we found that the provider had not received all documentation for staff employed in line with schedule 3 guidance. For example; references, qualifications, photo identification. After the inspection, we were sent evidence the provider had most of these records. There was no evidence that the registered manager had sought to gain reference from a previous employer in line with schedule 3. This had not been risk assessed.
- Relevant professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.
- On the day of inspection, the registered manager was able to show us evidence of their own training records, however, were unable to provide evidence of the employed staff members mandatory training. After the inspection, we were sent evidence of their own up to date records and their staff members training records. The employed staff member had completed safeguarding training, staying safe training and information security and data protection training. There was conflicting documentation when identifying mandatory training. For example, there were policies in place

that stated all staff should have infection control and equality and diversity training, however there was a separate document which we were sent post inspection that staff employed were only required to have safeguarding training, staying safe training and information security and data protection training. Due to conflicting policies and documentation, it was unclear what the expectation for staff employed was.

Coordinating patient care and information sharing

Staff worked together and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. If the provider could not meet the patients needs, they would signpost them onto the National Health Service (NHS) or to alternative independent health providers.
- Before providing treatment, clinicians at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. The provider sought information and shared information with relevant health care professionals where appropriate. All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- The provider had risk assessed the treatments they offered. The provider did not prescribe or hold any medicines liable to abuse or misuse. All consultations were shared with the relevant healthcare professionals, including GP's with the patients consent. Where patients did not want to consent, the benefits were explained and a copy was given to the patient to encourage them to pass this on.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. Where patients were unable to consent to treatments due to lack of capacity, the provider would offer best interest treatment in line with guidance and agreement with the patients' family or friends.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.
- The service monitored the process for seeking consent appropriately.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. The provider told us they would give dietary and lifestyle advice to patients which would be shared with the GP with their consent.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

Patients reported they were treated respectfully and were involved in the decisions made about their treatment.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way the provider treated people. For example, patients reported to us:
  - Appointments availability was effective and efficient.
  - Staff were professional.
  - There was always time to discuss results, concerns and medical terminology.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. The building had a mobile hearing loop to support patients with hearing loss and information leaflets were available in easy read formats, to help patients be involved in decisions about their care.

Privacy and Dignity

The service respected respect patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service provided care and treatment which was responsive to patients needs.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. Where the provider had a busy clinic, they employed a technician to support them so they could maintain quality of care and time for patients.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example:
  - The premises were accessible for wheelchairs, including access from parking facilities.
  - Where patients continued to shield themselves as a result of the COVID19 pandemic, the registered manager would ask patients what steps they could take to make a patient feel comfortable to attend. This may include the increased use of personal protective equipment such as masks and gloves.

Timely access to the service

Patients were able access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way. Where a referral was required, the provider would signpost patients. If required, the patient would be provided a letter explaining the need for a further referral.
- The provider's services did not extend to urgent care. They offered appointments on a Friday, but patients could be flexible to booking time.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

- The service had a complaint policy and procedures were in place to investigate and respond appropriately. Although the provider told us they had not received any complaints, they had actively sought feedback from patients, which reflected the positive experience of the clinic.
- On the day of inspection, the complaints policy signposted patients who were unhappy with the outcome of their complaint to the Ombudsman for NHS care and treatment. After the inspection, we were sent evidence that the provider had signed up to an independent complaints body and adjusted their policy and information accordingly.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- Policies and procedures were not always clear and held conflicting information.
- National guidance was not always followed in relation to staff employed.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The service provided a small-scale service totalling approximately 300 appointments in the last 12 months to new and existing patients for CQC regulated activities.
- Although the registered manager monitored the service for changes that could be made and may seek support or advice from other clinicians, they did not document or record any actions taken. Conversations with peers were informal and therefore a record was not kept.
- This was a single-handed provider with occasional support from a bank staff member. They worked closely with the buildings management and the external administration company to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills. Due to the scale of the service, the provider recognised they were the sole clinician to provide care for the service. In the event they were unable to complete the work, plans would be made for patients to be referred either to the NHS or another independent provider, which was within the limited business continuity plan.

Vision and strategy

The service had clear vision to deliver high quality care and promote good outcomes for patients.

- The provider had a clear aim and values. The service had a realistic strategy and would monitor their values through patient feedback and audit.

Culture

The service had a culture of high-quality sustainable care.

- The service focused on the needs of patients.
- There was a policy in place to support the provider to act on any behaviours of staff that were not in line with the values of the service.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There was a policy in place to support staff to raise concerns both internally and externally to the relevant bodies should this be required.
- The registered manager had completed their appraisal in line with GMC registration. The employed bank staff member had not received an appraisal but the provider had completed a competency check list. The registered manager told us, due to the small sized scale of the service, the staff member was present on an occasional basis and would have open conversations about patient care and performance when they were at work. However, it was within one of the services procedures that staff should have an annual personal performance development review.

Requires Improvement

Are services well-led?

- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. The provider had completed equality and diversity training but the staff employed had not. There was 1 policy that identified staff should receive this training and another document that stated it was not. Mandatory training standards were unclear and not always in line with policies.
- The leader sought to respond to concerns raised by CQC to rectify them.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, however they were not always effective.

- Structures, processes and systems to support good governance were in place. We found some areas of governance such as policies had multiple documents duplicated information within the building policies and those developed by the external company that provided admin support. For example,
  - A short chaperone policy which detailed how to gain a chaperone only and a chaperone guidance document.
  - We obtained 4 different documents for various different aspects of safeguarding which would benefit from being reviewed and streamlined for ease of access to staff who may need to make a safeguarding referral.
  - We obtained 3 documents including 2 consent policies and consent protocol. Documentation contained similar processes, but it would be beneficial for these to have been reviewed for clarity to staff.
- We found areas where policies and procedures gave conflicting information surrounding staff training. For example, we found examples of 2 policies which told us all staff should received infection prevention training and equality diversity training. We were also provided with another document which stated staff employed were not required to complete this training. Due to the various documentation, policies and procedures, it left expectations of staff unclear.
- Staff were clear on their roles and accountabilities.
- There was no log of actions including completion held by the registered manager. This resulted in them being unable to evidence when actions or information was acted upon. For example, actions from an incident.

Managing risks, issues and performance

There were clear and effective around processes for managing risks, issues and performance.

- Premises risk assessments including fire safety, risks were monitored by the buildings manager and the provider was able to review these for their own records.
- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had processes to manage current and future performance. The provider monitored their own performance through audits and monitored competency of the person employed.
- The provider had plans in place in the event of a premises, equipment or staffing issue.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the patient feedback to monitor the service.
- The provider provided care and treatment in line with National Institute of Care Excellence (NICE) guidance and updates.

Requires Improvement

Are services well-led?

- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns including feedback from patients to shape services. For example:
  - Feedback from patients was obtained and signposted to give feedback to CQC.
  - We were told the provider would gain support or advice from peers where required, to make sure patients were given the best care, however this was not documented.
  - The registered manager had completed 360 feedback for their appraisal which included feedback from peers and patients.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation, however these were not always effective.

- The registered manager was responsible for their own learning and was prompted by an external company to complete mandatory training modules. At the time of inspection, the registered manager had reviewed competencies annually but did not monitor mandatory training completed by the staff member, including infection prevention training and equality and diversity training.
- The service made use of internal reviews of incidents. Learning was shared with the external buildings management and used to make improvements.
- Whilst the service was not actively involved in innovative work or quality improvement, they sought feedback from patients and continued to engage with peers to keep their knowledge relevant for their specialism.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Systems and processes failed to ensure all staff were inducted and trained suitably and effectively to mitigate safety risks for patients. For example, basic life support, infection prevention and equality and diversity training. • Policies and procedures were not always consistent or clear for staff to follow. • Recruitment checks had not been completed in full in line with service policies or schedule 3 guidance. This was a breach of Regulation 17 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • Staff immunisation history records were not in line with The Green Book National guidance for immunisation of healthcare staff. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.