The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Quality Report

Pensnett Road
Dudley
West Midlands
DY1 2HQ
Tel: 01384 456111
Website: www.dgoh.nhs.uk

Date of inspection visit: 28 June 2018
Date of publication: 06/09/2018

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Urgent and emergency services	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Dudley Group NHS Foundation Trust operates acute hospital services from three hospital sites:

- Russells Hall Hospital
- Corbett Outpatient Centre
- Guest Outpatient Centre.

In addition, the trust provides community services in a range of community facilities.

Core services provided at Russells Hall include urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care. The trust has approximately 669 inpatient beds, 31 escalation beds and 152-day case beds. The trust employs around 4,147 whole time equivalent staff (WTE). These included 482 medical staff, 1,225 nursing staff and 2,440 other staff.

The emergency department (ED) includes a paediatric ED and both provide care for the population of Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

Our inspection of the trust covered only the Emergency and Urgent Care core service of Russells Hall hospital.

In January and February 2018, we took enforcement action against this provider under Section 31 of the Health and Social Care Act 2008 by imposing urgent conditions upon their registration. We are continuing to monitor progress against these. We took this action as we believed people will or may be exposed to the risk of harm if we do not do so. After this inspection in June 2018 we took further enforcement action by varying the conditions upon their registration.

We carried out an out of hours, unannounced, focussed inspection on the morning of 28 June 2018 starting before 6am. We specifically looked at the safe and well-led aspects of our key lines of enquiry within the emergency department at Russells Hall. We further focussed on the areas of assessing and responding to patient risk, nurse staffing, medical staffing, leadership, governance and risk management. This was based on our findings of previous inspections and to monitor compliance of the conditions that we had previously imposed on the trust's registration.

Our Key findings were:

- Patients presenting to the emergency department did not always receive a robust assessment of their clinical presentation and condition during the triage process.
- We found the waiting time for triage assessment to routinely exceed one hour for patients who presented by other modes aside from ambulance presentations. This was particularly evident in the category of adult majors.
- We found that staff were unclear on what the triage categories meant for patients who were in the ambulance assessment areas.
- There was a lack of accountability for the safety of patients pre and post triage who were located within the waiting room.
- Staff were unable to describe what 'fit to sit' meant or any criteria for this assessment.
- The electronic tracking system did not allow for patients to be easily located within the department.
- We remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions.
- Some patients with suspected sepsis were not identified or managed appropriately.

Summary of findings

- There was a disconnect between leader's impression of key areas such as sepsis management in the department and what was happening in practice.
- Doctors appeared frustrated at the focus on sepsis and did not fully engage with the need to assess for sepsis.
- Local audits being completed for sepsis patients were providing false assurance on the management of this condition within the department.
- There was no clear accountability of which team was responsible for the patient once they had been referred to a medical speciality.
- Staff were not always using clinical judgement alongside NEWS scoring criteria.
- Care records were not always written and managed in a way that kept patients safe.
- Some staff raised concerns regarding incidences of poor leadership style from some of the executive team. They told us that this had led to a poor culture and working environment where some staff told us that they felt fearful and disempowered.
- There were no clear criteria for patients that could be put into the fit to sit areas of the department.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust MUST:

- The trust MUST ensure that all systems and processes in place to identify and manage patients with deterioration effectively are followed.
- The trust MUST ensure that staff record an accurate, complete and contemporaneous record of the care provided to patients.
- The trust MUST ensure there is sufficient numbers of staff, who are suitably trained and competent, to care for the number and acuity of patients.
- The trust MUST ensure that deaths in the service are reviewed robustly and where appropriate lessons from these are learned and shared.

Following the inspection, we told the provider that it must take some action to comply with the regulations and that it should make other improvements, even where a regulation had not been breached, to help the service improve.

We imposed a number of urgent conditions to safeguard patient's safety immediately following the inspection. These conditions related to the management of patients at risk of deterioration and the arrangements for assessing and triaging patients.

Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	We previously inspected all this core service in December 2017 and it was rated inadequate overall. This inspection was not rated as we specifically looked at the safe and well-led aspects of our key lines of enquiry. Therefore the overall rating from the entire department in December 2017 still stands. • Patients presenting to the emergency department did not always receive a robust assessment of their clinical presentation and condition during the triage process. • We found the waiting time for triage assessment to routinely exceed one hour for patients who presented by other modes aside from ambulance presentations. This was particularly evident in the category of adult majors. • We found that staff were unclear on what the triage categories meant for patients who were in the ambulance assessment areas. • There was a lack of accountability for the safety of patients pre or post triage who were located within the waiting room. • Staff were unable to describe what 'fit to sit' meant or any criteria for this assessment. • The electronic tracking system did not allow for patients to be easily located within the department. • We remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions. • Some patients with suspected sepsis were not identified or managed appropriately. • There was a disconnect between leader's impression of sepsis management in the department and what was happening in practice. • Doctors appeared frustrated at the focus on sepsis and did not fully engage with the need to assess for sepsis. • Local audits being completed for sepsis patients were providing false assurance on the management of this condition within the department. • There was no clear accountability of which team was responsible for the patient once they had been referred to a medical speciality.

Summary of findings

- Staff were not always using clinical judgement alongside NEWS scoring criteria.
- Care records were not always written and managed in a way that kept patients safe.
- Some staff raised concerns regarding incidences of poor leadership style from some of the executive team. They told us that this had led to a poor culture and working environment where they felt fearful and disempowered.
- There were no clear criteria for patients that could be put into the fit to sit areas of the department.

Russells Hall Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to Russells Hall Hospital

Russells Hall hospital is in the heart of the Black Country, it covers a population of around 450,000 people in mainly urban areas. Russells Hall is part of The Dudley Group NHS Foundation Trust.

Core services provided at Russells Hall include urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care. The trust has approximately 669 inpatient beds, 31 escalation beds and 152 day case beds. The trust employs around 4,147 whole time equivalent staff (WTE). These included 482 medical staff, 1,225 nursing staff and 2,440 other staff.

The emergency department (ED) includes a paediatric ED and both provide care for the population of Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

The main ED consists of a dedicated ambulance triage area, a separate triage room for walk in patients, a resuscitation area with a dedicated space for paediatric patients. The treatment cubicles in the major's area include high dependency cubicles to monitor patients who are not yet ready to be transferred to a ward, and a minors' area with a dedicated ophthalmology assessment room.

Patients also have access to the Ambulatory Emergency Care Unit (AECU). Patients can also be directly admitted to paediatrics department, stroke unit, and cardiology unit when appropriately referred from other settings.

Our inspection team

A head of hospital inspection led our inspection team. The team included an inspection manager, an enforcement manager, a CQC inspector and one specialist advisor.

How we carried out this inspection

We carried out an unannounced, responsive, focussed inspection to establish whether the trust was meeting their duties under The Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and the conditions that had previously been imposed upon the trust's registration. We inspected specific parts of the safety and well- led domain within the Emergency and Urgent Care Core service.

Detailed findings

We previously inspected all this core service in December 2017 and it was rated as inadequate overall. We conducted a further inspection of the safe domain of the Emergency and Urgent Care core service in March 2018 which was not rated however we found serious issues remained within the department.

During this inspection, we inspected the Emergency and Urgent Care department on the morning of 28 June 2018. We reviewed staffing numbers, the skill mix of nursing and medical staff as well as the use of bank and agency staff. We spoke with medical, nursing and clinical support staff about their experience of working in the department. We also spoke with patients so we could obtain their views on the quality of care they were receiving.

During the inspection we reviewed patient records which included observation charts, screening tools and risk assessments, care plans and medical clerking documentation. We also observed a staff handover where the nurses discussed the patients in the department, their needs and levels of required observation.

Urgent and emergency services

Safe	
Well-led	
Overall	**Inadequate**

Information about the service

The trust had one Emergency Department (ED), located at Russell's Hall hospital.

Russells Hall hospital is in the heart of the Black Country area it covers a population of around 450,000 people in mainly urban areas. The emergency department (ED) provides care for the population at Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

The trust also provides a paediatric emergency department which also provided a 24-hour service. The paediatric emergency department was a small area within the main department and consisted of a small reception area with a corner for children to play with toys, three cubicle spaces and one triage room. The paediatric department was segregated from the main department by lockable doors which were only accessed by authorised staff using a swipe card system.

The main ED consisted of a dedicated ambulance triage area with 12 cubicles, and a separate triage room for patients. A four-bedded resuscitation area, with one dedicated space for paediatric patients. 16 treatment cubicles in the major's area (nine that were used for newly presenting patients and seven High Dependency cubicles to monitor patients who are not yet ready to be transferred to a ward). There was also a dedicated minors' area with a dedicated ophthalmology assessment room.

There were 170,000 attendances from April 2017 to March 2018 at The Dudley Group NHS Foundation Trust. The percentage of attendances resulting in an admission was 26% which was higher than the England average of 21.6%. This had also decreased from 2015/16.

There was an urgent care centre co-located with the emergency department. An external provider ran this centre. At the main ED reception desk, a 'streaming nurse' who worked for the urgent care centre (UCC), saw all self-presenting patients who attended ED at the hospital. Patients with minor illnesses or injuries were diverted either to UCC or to the minors' area within the emergency department.

The UCC was located further down the corridor from ED and both ED and the UCC shared the same reception area.

ED at Russells Hall hospital was last inspected by CQC in December 2017, as part of the new hospital inspection programme.

At that time urgent care services were rated as 'Inadequate'.

We inspected the service but did not rate it as we focussed our inspection on specific areas.

We reviewed 18 patient records throughout our inspection and we spoke with 12 staff and seven patients.

Urgent and emergency services

Summary of findings

For what we found on our previous inspection, look here:

http://www.cqc.org.uk/provider/RNA

Are urgent and emergency services safe?

We did not rate the safety of the service on this inspection, but we found:

- Patients presenting to the emergency department did not always receive a robust assessment of their clinical presentation and condition during the triage process.
- We found the waiting time for triage assessment to routinely exceed one hour for patients who presented by other modes aside from ambulance presentations.
- There was a lack of accountability for the safety of patients pre or post triage who were located within the waiting room.
- Staff were unable to describe what 'fit to sit' meant or any criteria for this assessment.
- The electronic tracking system did not allow for patients to be easily located within the department.
- We remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions.
- Some patients with suspected sepsis were not identified or managed appropriately.
- There was a disconnect between leader's impression of sepsis management in the department and what was happening in practice.
- Doctors appeared frustrated at the focus on sepsis and did not fully engage with the need to assess for sepsis.
- Local audits being completed for sepsis patients were providing false assurance on the management of this condition within the department.
- There was no clear accountability of which team was responsible for the patient once they had been referred to a medical speciality.
- Staff were not always using clinical judgement alongside NEWS scoring criteria.
- Care records were not always written and managed in a way that kept patients safe.

However,

- The streaming process was working within the department.
- Staff used a recognised tool to monitor patients, known as the National Early Warning Score (NEWS).

Incidents

- We did not inspect this area. However, we were made aware of a number of serious incidents which had been reported since the last inspection. Some of these incidents reflected concerns which had been identified in our previous inspections. An example of this was a patient who had presented with signs of serious illness and had been placed back in the waiting area. They had then suffered a cardiac arrest and died.

Environment and equipment

- Cubicles in the ambulance triage area were not visible from the nurses' station and the environment was not fit for purpose.
- The cubicles were very small and did not allow pat sliding and hoisting without compromising patient dignity.
- Ambulance staff members told us that they found it difficult to transfer patients in such cramped spaces.
- The area was also not secure and could be accessed from the main corridor. It also allowed patients to leave the area unseen. Staff told us that they did not always have enough staff members to provide one to one supervision for patients in confused states. This posed a significant risk that patients could leave and come to harm.

Records

- Care records were not always written and managed in a way that kept patients safe. The records we looked at were not always accurate and complete and were not accessible to agency staff. For example, a patient who had been receiving treatment in the resuscitation area for four hours had no nursing documentation recorded throughout this period.
- The new 'e obs' system repeatedly crashed whilst staff and CQC team members were attempting to navigate it.

Safeguarding

- We did not look at this area in detail during this inspection as we are currently receiving weekly data from the trust in relation to safeguarding within the department. Our monitoring information in relation to the conditions we imposed on the trusts registration showed that although there had been improvements to safeguarding children practice in the department, issues remained. The issues which remained centred on staff not recognising when they needed to alert senior staff when they identified safeguarding issues.
- We were also made aware after the inspection of two cases where suspected non- accidental injuries had not been identified and acted on appropriately. These incidents were being investigated and had been reported as serious incidents.

Assessing and responding to patient risk

- Staff did not routinely undertake patient's observations at triage.
- Staff were aware of the triage system and what it was in the main triage room and paediatrics areas. However, staff could not tell us what the categories meant for patients in the main ambulance assessment areas.
- We noted during inspection that patients who were placed into triage category 2 'cannot wait' routinely waited excessive times of up to four hours to be seen by a clinician and were placed into the waiting room.
- We found the waiting time for triage assessment to routinely exceed one hour for patients who presented by other modes aside from ambulance presentations. This was particularly evident in the category of adult majors. This was not always escalated or acted on by senior staff in line with the trusts own policy.
- Patients awaiting triage during this time included those with sign of serious illness including stroke, chest pain, feeling faint and bleeding in pregnancy.
- There was no oversight of patients pre and post triage in the main waiting room.The triage nurse and senior staff told us the responsibility for these patients lay with the receptionist staff as it was impractical to expect the nursing staff to have clinical oversight of these patients.

Urgent and emergency services

- Four out of five nursing staff questioned about who was accountable for the waiting room patients told us that it was the non-clinically trained reception staff. The other staff member told us that this accountability lay with the nurse in charge. However, they acknowledged that the nurse in charge had 'too much to do' to monitor the waiting room.
- A band 6 nurse told us that when she was in charge she would 'do a sweep' of the waiting room patients on the electronic tracker as this was a practice she had adopted from a previous role but admitted she was aware other staff members did not do this.
- Nursing staff confirmed that they did not check patients in the waiting room unless waiting times exceeded a high number of hours at which 'quality rounds' would be instigated.
- They also confirmed patients in the waiting room did not receive observations as they had been determined as 'fit to sit'. However, they were unable to describe what fit to sit meant or any criteria for this assessment.
- Nursing staff told us that unwell patients were accommodated in the waiting room when 'there was no room' and these were sometimes forgotten and could be 'bumped' back by ambulance arrivals.
- Reception staff, the triage nurse and the nurse in charge were not notified when ambulance patients were placed in the waiting room. The decision as to who could sit in the waiting room from ambulances was unclear with staff saying it could be the triage bay team or nurse in charge or the triage nurse themselves.
- Four members of staff told us that they would not be happy for their relatives to be seen at the hospital and wait in the waiting rooms as they would be worried that they may deteriorate or die and that they would accompany them to the hospital or take them elsewhere.
- The streaming system appeared to be working more effectively than during previous inspections. Patients would present to the main department where they would initially be seen by a nurse with advanced skills in clinical assessment. This nurse was employed by a neighbouring organisation. This nurse would make a quick assessment of the patients presenting conditions then 'stream' them to either the urgent care centre or through to the ED where they would then be triaged by the trust. However, patients were still required to complete a lengthy form on a clipboard when they met the first nurse. This was not cleaned between uses and there was no provision for patients who could not read or write and if English was not their first language.
- During the inspection we sat in the reception area for two 30-minute periods and observed that there were three patients who appeared very unwell and in two cases members of the public raised concerns for their safety.
- One patient was a patient bleeding profusely. The triage nurse was called after the member of the public alerted reception staff. They dressed the wound and sat them back in the main waiting area and within 15 minutes another member of the public approached the desk and raised concerns. The wound was again bleeding through and the patient appeared unwell. Reception staff alerted the triage nurse again, approximately 15 minutes passed and CQC noted they remained in the area with blood oozing out onto their clothing and the floor. At this point CQC intervened and requested they be seen and attended to due to concerns for their immediate safety. Staff then took the patient for treatment.
- In another case a patient appeared very pale and unsteady. A member of the public alerted reception staff who alerted the triage nurse. The patient then attended the triage door and was unsteady on their feet. The triage assistant instructed them to sit back in the waiting room.
- We found that the electronic tracking system did not identify which patients were in the main waiting area. For example, at one point there were 78 patients in the department and approximately 40 patients in the main waiting room. However, on the electronic tracking system there was only one patient allocated to the main waiting room.
- Staff told us that all other patients were categorised as 'majors or minors' however without physically checking each area of the department staff could not tell which patients were in which areas.

Urgent and emergency services

- During the inspection we attempted to locate a patient who had been booked in with signs of having a stroke. It took CQC staff 40 minutes to locate where the patient was in the department. It was established they were in the main waiting room and had waited over an hour for triage.When CQC staff were trying to locate the patient the nurse in charge of the department suggested CQC calling their name in each area of the department to find him.
- Sepsis screening was still not undertaken for all patients.
- Some patients displaying sepsis 'red flag' symptoms on arrival did not have sepsis screening or pathway tools completed or in place.
- The assessment, screening and treatment for sepsis was delayed in all cases that we looked at during the inspection.
- There was a disconnect between what leaders thought was happening in the department and what was happening in practice. For example, the lead nurse and ANP felt that sepsis was well managed in the department. However, the evidence we gathered showed that it was not managed effectively in all cases reviewed and staff lacked a basic knowledge of what sepsis was, what the signs were and had failed to recognise clear cases.
- When nurses attempted to challenge doctors, doctors did not take their contribution into account. An example of this was when a nurse went to a doctor to raise concerns about a patient with signs of infection and ask if they were septic. The doctor did not agree that the patient had an infection, however the patient was being treated for an infection with IV antibiotics.

- Doctors were frustrated at the focus on sepsis and did not engage with the need to assess for sepsis. They failed to identify and act on potential signs of sepsis. Their assessment was based largely on whether the patient had a temperature or not. An example of this was a patient who was later diagnosed with sepsis had a heart rate of 130bpm and was receiving IV antibiotics. This value would have triggered the sepsis red flag system and necessitated a sepsis screen and pathway. However, both the nurse and doctor caring for the patient did not agree that the patient might have sepsis.
- The local audits being completed to fulfil the conditions on the trust's registration and provide assurance to the executive team and the CQC focused on how quickly from 'time zero' the patient was assessed and received antibiotics. This meant a patient could be in the department for a number of hours with signs of an infection and encounter a delay in prompt antibiotic therapy but their treatment would show as compliant upon the audit. Therefore, this audit was providing false assurance on the management of septic patients.
- An example of this was a patient who arrived in the department before 6am. The patient showed clear signs of infection including, low temperature, high heart rate, high respiratory rate and low oxygen saturations. Their observations were not undertaken until after 7am. At which point their National Early Warning Score (NEWS score) was 10. It was only at this point the sepsis screen was undertaken and the time zero was documented as the time the first set of observations were taken. However, the patients 'time zero' was an hour earlier.
- A further case related to a patient who was undergoing active chemotherapy and had presented with high temperatures and feeling unwell. Their sepsis screen was not undertaken for over an hour.
- Staff used a recognised tool to monitor patients, known as the National Early Warning Score (NEWS).
- We saw improvements in how frequently patient's observations were being taken in the major's area. However, we remained concerned about how quickly and appropriately staff were responding to patients with serious and deteriorating conditions. However, nursing staff did not always use clinical judgement and were following the NEWS scoring system alone to dictate the frequency of observations for patients in the majors and ambulance triage area. As a result, patients with potentially life-threatening symptoms and conditions were not being monitored and escalated adequately.
- For example, a patient had presented following a severe assault and received kicks to the abdomen and head. They had lost consciousness. They were placed on four hourly observations because they had a low NEWS score.

- In another case a patient presented with a concerning NEWS score and was being managed in the ambulance triage area. Staff had to be prompted by CQC staff to escalate the patient who was then moved to resuscitation area and became critically unwell.
- The arrangements for the monitoring and escalation of patients waiting to be admitted to acute medical wards remained unclear, with no clear accountability of which team was responsible for the patient once they had been referred to medicine. The department was working in silo of the specialities and staff remained unclear on who cared for these patients.

Nursing staffing

- The ambulance triage area was staffed with two registered nurses and could be flexed up to accommodate 18 patients. At full capacity this area was understaffed as major's patients require 1:4 nursing care.
- We reviewed staffing rotas and found that shifts routinely ran with less nursing staff than required.

Are urgent and emergency services well-led?

We did not rate well-led for urgent and emergency services during this inspection but we found the following:

- During the inspection some staff raised concerns regarding incidences of poor leadership style from some of the executive team. They told us that this had led to a poor culture and working environment where they felt fearful and disempowered.
- There were no clear criteria for patients that could be put into the fit to sit areas of the department.

Leadership and culture of service

- During the inspection some staff raised concerns regarding incidences of poor leadership style from some of the executive team. They told us that this had led to a poor culture and working environment where some staff told us that they felt fearful and disempowered.
- Some staff told us that they felt some senior leaders (members of the divisional and executive leadership team) did not understand what was happening in front line services and that they put initiatives into place with no clinical consultation.
- Some staff told us that they raised concerns about the safety of some of these initiatives and that some senior leaders (divisional and executive leaders) did not take these on board or action them. An example given of this was the opening of the ambulance triage area. Some staff told us that they had repeatedly raised concerns about the safety of this area and its operation and had not seen any remedial action taken.
- There appeared to be a clear separation between medical and nursing teams and between ED and the medical specialty teams.
- Staff said there was a lot of looking around by senior staff but no real help was offered, one staff member described the department as 'organised chaos' which ground to a halt when any challenges were presented.
- Staff were positive about some local nursing leaders (departmental sisters and matrons) and told us that they felt they were supported by them.
- We did see some examples of strong nursing leadership from some senior sisters in the department. However, we found that despite this the nursing leaders did not have the tools and systems in place to allow them to have full oversight of all patients in the department. This meant they could not effectively plan for any surges in activity.

Governance, risk management and quality measurement

- The information the executive team were relying on for assurance was not robust or accurate in all cases. Some staff told us the audits undertaken to measure the compliance of NEWS scoring were on some occasions 'handpicked' to ensure good results. We also found that the time zero for sepsis auditing was not always correct. This meant the trust board were receiving falsely positive data.

Urgent and emergency services

- There were no clear criteria for which patients were fit to be placed in the ambulance triage area or any specification on how long they should remain in that area.
- There were no clear criteria for the fit to sit areas in the department.
- The NEWS and observations alerts on the new 'e obs' system were defaulted to 4 hourly. Staff informed us that this frequency could not be changed so alerts were not being issued for patients who needed a higher level of care.
- We found concerns with the review of deaths within the emergency department. We found that staff involved in the care of patients were able to undertake their own reviews of deaths. We found in a number of cases that robust mortality reviews had not been undertaken. An example of this was a patient who had died after being placed in a triage category which indicated that the patient should be seen immediately and was placed back in the waiting room. The mortality review did not identify this issue.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Following our previous inspection, we took enforcement action to ensure the trust were addressing the risks to patients. In addition to this action the hospital MUST take the following action to improve:

- The trust MUST ensure that all systems and processes in place to identify and manage patients with deterioration effectively are followed.
- The trust MUST ensure that staff record an accurate, complete and contemporaneous record of the care provided to patients.
- The trust MUST ensure there is sufficient numbers of staff, who are suitably trained and competent, to care for the number and acuity of patients.
- The trust MUST ensure that deaths in the service are reviewed robustly and where appropriate lessons from these are learned and shared.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.— Safe care and treatment. 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include - a) assessing the risks to the health and safety of service users of receiving the care or treatment; b) doing all that is reasonably practicable to mitigate such risks; c) ensuring that persons providing care or treatment to service users have the qualification. competence, skills and experience to do so safely. Following this inspection we varied the conditions on the providers registration.