East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at William Harvey Hospital

Requires Improvement 

We carried out an unannounced focused inspection of the emergency department at William Harvey Hospital following the 'Resilience 5 Plus' process. The 'Resilience 5 Plus' process is used to support focused inspections of urgent and emergency care services which may be under pressure due to winter demands or concerns in relation to patient flow and COVID-19.

We did not inspect any other services as this was a focused inspection in relation to urgent and emergency care. We did not enter any areas designated as high risk due to COVID-19. The inspection framework focused on five key lines of enquiry relating to critical care, infection prevention and control, patient flow, workforce and leadership and culture.

We previously inspected the emergency department at William Harvey Hospital in March 2020 as part of our comprehensive inspection methodology. We rated it as requires improvement overall and imposed conditions relating to the emergency department. The conditions were monitored prior to, and separately from, this inspection. The conditions were removed on 29 March 2021 following improvements made by the trust. Therefore, the rating limiter due to the level of enforcement action which restricted the rating to inadequate in the key question of safe no longer applies and it has improved to a rating of requires improvement.

How we carried out the inspection

We spoke with 28 staff across a range of disciplines including lead nurses, senior nurses, healthcare assistants, emergency department consultants, trust grade doctors, junior doctors, matrons, ambulance crews, the care group head of nursing, and the care group clinical director. We attended emergency department safety huddles and a patient flow meeting.

As part of the inspection, we observed care and treatment and looked at six care records. We analysed information about the service which was provided by the trust.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Urgent and emergency services

Requires Improvement 

Our rating of this service stayed the same. We rated it as requires improvement because:

- The design and use of premises did not always keep people safe. At the time of our inspection, the mental health quiet room in the non-COVID area did not comply with national standards. However, the trust took action immediately following our inspection to rectify this. They had also made improvements to create suitable and designated spaces for the treatment of deteriorating Covid-19 positive patients.
- Staff did not follow the trust's deteriorating patient policy in relation to the frequency of which they took and recorded clinical observations. Waiting areas were not in direct line of sight of staff and could not be easily observed.
- Patient record systems were not fully integrated, which meant patient notes were not always easily accessible to those who needed them.
- The service did not always have enough nursing staff with the right qualifications, skills, training, and experience. However, we saw this was well managed and the trust were developing business cases to expand the nursing workforce to match increased demand.
- People could not always access the service when they needed it, and it was not always timely. The department was not meeting the national four-hour performance target which meant patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough medical staff with the right qualifications, skills, training and experience which met with Royal College of Emergency Medicine recommendations.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement because:

Urgent and emergency services

Environment and equipment

We were not assured the design and use of premises always kept people safe. However, the trust had made improvements to create suitable and designated spaces for the treatment of deteriorating Covid-19 positive patients.

Since our last inspection, the department had designated areas for the treatment and care of patients with COVID-19, in line with national guidance. The trust had implemented blue and red zones within the emergency department to maintain patients and staff safety.

Blue zones were designated high-risk zones for COVID-19 positive patients which enabled staff to provide appropriate care and treatment for these patients. Red zones were designated as safe areas for patients not suspected of having COVID-19. However, the physical emergency department layout was not helpful in maintaining optimal patient flow. Different areas and patient pathways within the emergency department were dispersed meaning staff did not always have clear line of sight of patients. Also, patients sometimes had to navigate themselves around the department when moving from one area to another. We observed patients who were unsure where the waiting room was located and where to sit.

Staff followed the trust's social distancing escalation process which determined if the department was becoming full. The nurse in charge was able to see this displayed on the emergency department electronic dashboard and also undertook hourly visual checks to ensure compliance. Throughout the emergency department footprint, space was limited and staff told us it was challenging to always maintain social distancing. Although social distancing was hard to maintain all the time, staff did follow infection prevention and control principles including the use of personal protective equipment. There were clear screens situated within all waiting areas to separate patients. We saw that this worked effectively. All cubicles in the blue and red areas within minors, majors and resus had clear plastic curtains to separate patients.

The blue area of the emergency department had a designated mental health quiet room which met national standards as outlined by the Psychiatric Liaison Accreditation Network. In the red area, staff used the relative's quiet room, when needed, as a mental health quiet room. This room did not meet national standards.

We noted the room had ligature points, which is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. There were no panic alarms and no second internal door staff could access in the event of an emergency. These presented risks of harm to both patients and staff. The department were aware of the issues with the mental health quiet room. These were highlighted on the department's risk register and described mitigations in place to ensure both patient and staff safety while using the room. This included patients being continually observed on a one to one basis with a suitably trained member of staff. However, on the day of our inspection, we saw a patient in the room without appropriate one to one supervision, as the staff member had gone on a break, despite the patient being at risk of self harm. We highlighted this to the department who took immediate action.

Following the inspection, the trust provided us with plans to adapt the room, together with an action plan, to bring the room in line with national standards for mental health assessment rooms. The trust confirmed all adjustments will be completed by 21 April 2021. However, the trust would make immediate adaptations would be made to make the room safe for use by the end of March 2021.

Urgent and emergency services

Staff adhered to the appropriate personal protective equipment requirements throughout the emergency department. We also saw staff challenge colleagues when trust personal protective equipment requirements were not being met, for example when wearing gloves and aprons in corridors or when providing direct patient care.

Aerosol generating procedures are treatments where infectious material can become airborne and therefore require staff to wear a higher level of personal protective equipment. We saw the service had created two negative pressure side-rooms from existing side-rooms in the department. This created a designated space for the treatment of deteriorating Covid-19 positive patients who required resuscitation or an aerosol generating procedures. Staff working in these rooms wore personal protective equipment that was in line with the trust's personal protective equipment policy.

There was a 'make-ready' room attached to the aerosol generating procedures rooms, where staff could prepare equipment prior to entering the side-rooms. All the rooms were connected via audio and visual technology so both staff and patients did not feel isolated. This also allowed staff to communicate with colleagues for help and guidance without the need to change personal protective equipment.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Since our last inspection the trust had improved its cleanliness, infection control and hygiene processes and procedures. The trust had effective systems to ensure that standards of cleanliness and hygiene were maintained and offered protection and safety for staff and patients.

All areas of the department were visibly clean. Cleaning schedules showed there was regular cleaning of the department throughout the day. Staff cleaned all chairs and trolleys between patients. We saw teams of cleaning staff working within the department throughout our inspection. Staff told us they could request additional cleaning for specific areas, such as the negative pressure side-rooms.

Staff followed the trust's infection, prevention and control policies, such as correct uniform, use of personal protective equipment and being bare elbow the elbow. Hand sanitisers were available throughout the department. Posters displayed in the department encouraged staff and patients to wash their hands. Hand hygiene audit results were displayed, and compliance on the day of our inspection was 96.27%. This information was available in real time on the service dashboard.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff told us they were supported by the safeguarding team and able to discuss safeguarding and any concerns they had.

Urgent and emergency services

The trust had a safeguarding policy, as well as guidelines and information to support staff to recognise and manage cases of suspected domestic violence and assault. Staff knew the process of how to complete a safeguarding referral and worked closely with the safeguarding team.

We saw safeguarding pathways were used in the paediatric emergency department. All children and young people were assessed for safeguarding or concerns on arrival and a clear process of guidelines for safeguarding were in place. There was a weekly paediatric safeguarding meeting to discuss any safeguarding concerns.

The service provided staff with weekly safeguarding supervision in addition to attending safeguarding review meetings, with lessons learnt shared.

The matron or senior nurse attended frequent attender meetings with NHS ambulance and mental health trusts. The meeting was also attended by the safeguarding team. The trust had worked with a local charity, mental health trusts, GP's and police around providing safeguarding liaison support within the department.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. Staff did not follow the trust's deteriorating patient policy in relation to the frequency of which they took and recorded clinical observations. Waiting areas were not in direct line of sight of staff and could not be easily observed.

A senior nurse took the role of navigator and was positioned at the ambulance entrance. The navigator greeted ambulance crews. The navigation nurse informed ambulance crews when it was safe to bring their patients into the department. If the patient was deemed as suspected or confirmed Covid-19, the patient went to the blue area, dedicated for suspected Covid-19 patients.

Patients who self-presented in the department were initially seen by a streaming nurse who directed patients to the most appropriate clinical pathway. The streaming nurse asked basic screening questions using a COVID-19 criteria tool. Responses to these questions and basic observations such as blood pressures were not recorded on the emergency department clinical system. Patients were not registered into the department at this point.

At the direction of the streaming nurse they would immediately go on to present themselves to either the emergency department or GP-led urgent treatment centre reception desk. The GP led urgent treatment centre was based within the emergency department.

This approach was in line with the Royal College of Emergency Medicine's recommendations, which state the process of directing patients before a formal clinical assessment is most safely undertaken by a clinician.

There were two pathways for patients attending the department depending on whether they were potentially COVID-19 positive or not. Streaming allowed patients to be placed into the designated blue or red pathway areas safely. Patients who answered yes to any of the potential COVID-19 questions, were referred to the blue pathway. All other patients were directed to the emergency department reception desk, where they were booked in for triage.

Once booked in the patients sat in the emergency department waiting room which was located a short walk down a corridor and was formerly the fracture clinic waiting room. The waiting room had chairs which were separated by clear plastic screens. This ensured effective social distancing was maintained and the area was able to be cleaned effectively.

Urgent and emergency services

Following feedback from patients, the service had created a separate waiting room off this main waiting room, for patients who were shielding. The shielding waiting room had chairs which were separated by clear plastic screens. This ensured effective social distancing was maintained and the area was able to be cleaned effectively.

Staff could not easily observe the waiting rooms as they were not in direct line of sight of staff. There were no emergency call bells in the waiting areas. This meant staff would not be able to easily see if a patient's condition deteriorated.

Staff we spoke with described how difficult it was to maintain visibility of patients due to the layout of the department. They explained this was a challenge when the department was busy.

We highlighted our concerns to the trust during the inspection. The trust told us triage staff, who collected patients from waiting areas, checked on patients. We saw this practice taking place. However, this process had not been formalised and there were lengthy periods when patients were not checked. After the inspection, the trust confirmed that an additional member of staff had been assigned to formally oversee patients in the waiting areas.

All clinical staff we spoke with knew how to recognise and respond to the deteriorating patient and staff told us they had received training in how to escalate the deteriorating patient.

Patient observations were recorded, and staff used a nationally recognised early warning score tool (NEWS), to identify deteriorating patients. NEWS is a simple, physiological score that may allow improvement in the quality and safety of management provided to patients. The primary purpose is to prevent delay in intervention or transfer of critically ill patients. Observations and NEWS scores were displayed on the trust's electronic system at the nursing station, so staff were able to observe patients at risk of deterioration.

We reviewed six sets of patient records during our inspection, four of which showed clinical observations had not been carried out at the required intervals and in line with trust guidelines. Trust patient record audit data reviewed after the inspection also showed percentage compliance rates of 35% January 2021 and 46% February 2021, against a target of 100%.

Patients were not always seen within the national standard of 15 minutes of arrival to the department. In part, due to COVID measures put in place, the dispersed nature of the department impacted on the effective flow of patients from reception to the waiting areas. We saw patients walking down corridors unsure where the waiting room was located. There were no reception staff allocated to the waiting area during our inspection. Therefore, when patients arrived, we saw they sometimes did not know if they were in the correct location or not.

Emergency department reception staff were unable to confirm if they had received formal 'red flag' training. 'Red flag' conditions are symptoms that may indicate the patient requires urgent assessment or treatment, for example chest pain. Reception staff told us they would use their experience to determine if someone looked like they required urgent assistance. Should this be the case they would contact the triage nursing team or a doctor. Self-presenting patients were seen by a streaming nurse prior to attending reception. However, the lack of formal training meant there was a risk reception staff may not always recognise 'red flag' conditions in a self-presenting patient.

The nurse in charge checked triage and patient waiting times as part of their two hourly safety checks and escalated any patients of concern. Staff would monitor waiting times directly from the electronic patient record and escalate patients who were waiting too long to be seen.

Nurse staffing

Urgent and emergency services

The service did not always have enough nursing staff with the right qualifications, skills, training, and experience. However, we saw this was well managed and the trust were developing business cases to expand the nursing workforce to match increased demand.

While the service did not always have enough nursing staff, managers regularly reviewed and adjusted staffing levels and skill mix to ensure safety within the department. Managers gave bank, agency and locum staff a full induction, this included an orientation of the COVID-19 and non-COVID-19 areas. Nursing staff would be dynamically deployed between the emergency departments of William Harvey hospital and the Queen Elizabeth Queen Mother hospital to ensure safe staffing levels. Nurse managers and nursing staff we spoke with told us this worked well.

Staffing levels were displayed, as well as the name of the nurse in charge and emergency physician in charge. We noted nurse managers took appropriate action to review staffing levels based on patient acuity. The nurse in charge explained how they planned four weeks in advance for all shifts to ensure they had the right staff with the right competencies and skills to manage the emergency department safely.

There were always two qualified children's nurses on duty in the paediatric emergency department. Advanced nurse practitioners from the children's ward also supported the paediatric emergency department. The emergency department lead consultant had completed additional paediatric training to provide support.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience.

Medical staffing met the Royal College of Emergency Medicine recommendations of 16 hours of consultant presence per day, with the remaining eight hours covered by an on-call rota. Junior medical staff provided cover 24 hours per day, seven days a week.

The service met the royal college of paediatric and child health's national guidance to provide a paediatric emergency medicine (PEM) consultant as per recommendation 9: EDs treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics. Additional paediatric consultant cover was available via the paediatric ward.

Medical staff would be dynamically deployed between the emergency departments of William Harvey Hospital and the Queen Elizabeth Queen Mother Hospital to ensure safe staffing levels. Medical managers and staff we spoke with told us this worked well. Where required, additional medical cover was provided by regular locum doctors. Locum staff received a full induction, this included an orientation of the COVID-19 and non-COVID-19 areas. Medical and orthopaedic doctors also supported the department with triaging medical patients.

Medical staff described good recruitment and retention within the medical grades. The trust had good development training for doctors which contributed to good retention. The trust had developed a variety of posts with training rotations to further aid recruitment, for example a resus fellow with six months based in critical care and six months in emergency medicine.

Doctors we spoke with confirmed regular teaching took place within the department. This continued despite challenges and pressures from COVID. Staff told us this was important and helped improve their practice and skills.

Records

Urgent and emergency services

Patient record systems were not fully integrated, which meant patient notes were not always easily accessible to those who needed them.

There was a new integrated IT system in the department for patient records. There was another electronic system for recording patient's clinical observations. Alongside the new patient record system and the clinical observation system, there was an older dashboard which flashed blood results on the patients' electronic record to attract the attention of staff.

Some staff did report using the various systems alongside each other was an issue and added delays to their work. We were concerned that using different systems for patient records meant there was potential for duplication of record keeping, error and not noticing a deteriorating patient.

The mental health assessment tool was not electronic. This meant the notes might not always be easily accessible to clinicians. For example, on the day of our inspection we observed a patient alone in the mental health quiet room. However, their notes were with the member of staff who was looking after them and that member of staff was on a break. This meant there was no access to clinical notes for this patient should staff in the department need them.

We raised our concern with the department leads who took immediate action. We also informed the trust leadership team during the end of day feedback who described plans to integrate their clinical systems and the paper mental health assessment tool into the new IT system.

Following the inspection the trust informed us enhancements to the clinical IT system would commence in June 2021.

Is the service responsive?

Inspected but not rated

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly.

In England, the national target for patients attending the emergency department to be treated, transferred, and discharged within four hours is 95%. The department was not meeting the national four-hour performance target which meant patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets. Against the national target of 95% trust data showed the emergency department had achieved 64% for January 2021 and 73.5% for February 2021.

A qualified streaming nurse saw all emergency department walk-in patients at the front door. The streaming nurse directed patients to the most appropriate clinical pathway/service based on a brief presenting history. This also included a GP led urgent treatment centre, located onsite. The streaming nurse assessed patients for COVID-19 symptoms before awaiting initial assessment. Patients who were COVID-19 symptomatic were streamed into a different pathway whilst those with no symptoms were asked to wait in the main waiting room for triage.

Urgent and emergency services

The GP from the urgent treatment centre was based within the emergency department. The urgent treatment centre received referrals from a direct access booking service and the emergency department.

Patients sometimes waited for long periods to access the care they needed. Once triaged, patients waited to see a doctor. Trust data showed 39.5% of patients in January 2021 and 38.6% of patients in February 2021, wait 60 minutes or less to be seen by a doctor or clinical professional.

Trust data showed 44.9% of ambulance handovers in January 2021 and 47.5%% of ambulance handovers in February 2021, took place within 15 minutes.

The site team managed hospital flow and we saw a site operations meeting chaired by the acting hospital operations director. This meeting reviewed the pressures of regional hospital sites and ambulance services, and their ability to manage and anticipate capacity across the system.

Department leads and department coordinators attended site team meetings daily to ensure that there was oversight of activity within the department. This allowed them to understand the potential impact of patients waiting for an inpatient bed. The site team facilitated potential blocks and delays within the hospital system to improve patient flow. We saw effective discussions around flow take place in these meetings.

Current emergency department positions and discharges were discussed. At the time of our inspection this meeting was held every two hours in line the hospital escalation protocol.

The service was following national guidance on the care and treatment of patients in emergency settings and was not queuing or cohorting patients in corridors. We observed no overcrowding in the emergency department during our inspection and no ambulances waiting to offload patients.

Ambulance crews would telephone the emergency department en-route, to give advanced warning if a COVID-19 positive, or suspected positive patient was due to arrive by ambulance. On arrival, the patient was immediately transferred into the negative pressure room. Staff told us this process worked well.

There were processes in place to monitor waiting times. Despite the challenges, managers and staff worked together to make sure patients did not stay longer than they needed to. Processes for monitoring waiting times were embedded in the day-to-day quality processes; staff discussed waiting times during safety huddles and the nurse in charge escalated any concerns regarding patients who were approaching a breach in waiting or triage times during their two hourly safety checks.

Patients discharged from the department were given advice on the next steps, for example if they needed to attend their GP or return to hospital.

Is the service well-led?

Inspected but not rated

Leadership

Urgent and emergency services

There was a stable leadership team in place and leaders had the skills and abilities to run the service.

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the services for patients and staff.

At the time of our inspection, we saw the trust had improved the emergency department management structure and had restructured the emergency department management team across both William Harvey Hospital and Queen Elizabeth Queen Mother Hospital. The leadership team included emergency department consultant leads on both sites, a head of urgent and emergency care across both sites and a dedicated operations manager at William Harvey Hospital.

The matron for urgent and emergency care worked with the emergency department lead nurse across both sites to ensure consistency of services and visibility of the nursing management team.

Leaders we spoke with told us there had been a positive impact on leadership during the COVID-19 pandemic as the team pulled together throughout the first wave and embraced different ways of working.

Staff spoke highly of the leadership team. They told us they felt emergency department leads were visible and supportive when they raised any concerns. Leaders provided clear escalation plans and processes and ensured that staff understood and followed them. They supported staff with changes.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.

Staff we spoke with described an open culture where learning from incidents was encouraged and staff were actively engaged in developments within the department.

Staff felt valued and felt the leadership team had provided additional support during the pandemic. A culture of working together had been a key focus to ensure patient and staff safety.

Staff were happy to talk to the inspection team and wanted to tell us why they enjoyed working in the department.

As a result of the challenges brought by COVID, staff reported working cohesively to ensure effective care and treatment. During our inspection, we saw mutually respectful interactions between staff of different grades and professions. Consultants told us they were working with speciality consultants to redesign patient pathways to improve patient flow through the hospital.

We spoke to a variety staff including junior doctors, healthcare assistants, junior nursing staff and the flow coordinators. All the staff were very complimentary about the senior leadership and each other.

Governance

Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Urgent and emergency services

During our inspection, we saw there was a clear governance structure. The department held a monthly emergency governance and patient safety meeting. Information and updates from the urgent and emergency care group fed into the executive team governance.

The governance meetings included governance updates, trends and themes, serious incidents, audits, updates from the mortality and morbidity group as well as current audits and care pathways.

Escalation plans and protocols had been implemented during the pandemic. The trust used a multi-disciplinary approach to managing key challenges within the emergency department. This included the management of flow using combined operational and clinical meetings with divisional teams to address key issues, for example, staffing levels, escalation and risk.

Staff we spoke with told us that leaders across the organisation engaged in improvement and escalation activities, for example, forums with clinical teams to discuss challenges and potential opportunities for performance improvement.

Managers we spoke with told us the trust's senior leadership team understood the challenges in relation to the quality and sustainability of effective patient care during the COVID-19 pandemic.

Management of risk, issues and performance

Leaders and teams used systems to manage risk however performance issues remained that impacted on the quality and safety of care.

Leaders identified and escalated relevant risks or issues and identified actions to reduce their impact though these were not always effective, such as in the long delays that some patients waited for care. Trust, care group and emergency department leads were aware of the department's challenges, for example the need to recruit substantive staff, and were actively working toward these goals.

We reviewed the emergency department latest risk register and found that risks were scored using a recognised risk tool. Risks listed included: COVID related concerns, long waits in the emergency department, delays in assessment/ treatment and oversight of patients at high risk of deterioration were recorded. There were controls in place to mitigate these risks where possible. Department leads reviewed and updated risks to reflect the current position and the changing situation.

The department had their own key performance indicators for appraisals, reattendance rates, waits in observation ward and persisting medical errors. The trust failed to meet some performance indicators due to the pandemic.

Patient FIRST is a tool designed by the CQC to support flow through emergency departments and reduce risks of overcrowding and nosocomial (hospital acquired) infections. At the time of our inspection, the trust was using our Patient FIRST document to improve emergency department performance relating to winter planning and pressure resilience. Staff we spoke with could describe the principles of the document and how they were using it.

Areas for improvement

MUSTS

Urgent and emergency services

- The trust must ensure the department had suitable facilities to care for patients with mental ill health. Breach of Regulation 12 (2)(b).
- The trust must ensure all patients are monitored for deterioration including those waiting for triage. Breach of Regulation 17 (2)(b).

SHOULDS

- The trust should consider reviewing the layout and flow of patients within the department.
- The trust should consider the accessibility of patient records for those who need them.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

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
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures Nursing care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment