

Southport and Ormskirk Hospital NHS Trust

RVY

Community health services for children, young people and families

Quality Report

Southport and Formby District General Hospital,
Town Lane, Southport. PR8 6PN
Tel:01704 547471
Website:www.southportandormskirk.nhs.uk

Date of inspection visit: 13 April 2016
Date of publication: 15/11/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
	PACE Clinic Bootle Clinic		
	Southport Centre for Health and Well Being		





This report describes our judgement of the quality of care provided within this core service by Southport and Ormskirk NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Southport and Ormskirk NHS Trust and these are brought together to inform our overall judgement of Southport and Ormskirk NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Requires improvement	
Are services well-led?	Requires improvement	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
Good practice	7
Areas for improvement	7

Detailed findings from this inspection

The five questions we ask about core services and what we found	8
Action we have told the provider to take	18

Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

We found the overall rating for this service as requires improvement because:

- The computer system did not consistently flag up patients with safeguarding concerns. Systems in place to address this were not robust across the service's different clinics.
- The number of staff that were up to date with their statutory and mandatory training were below the trust's target.
- The lack of an electronic patient record presented risk of patients attending multiple clinics unknown to staff.
- Patients were turned away from clinics which could not meet the demand and 168 clinics were cancelled in the 12 months to January 2016.
- The management team did not document, monitor or manage the numbers of patients turned away from clinics or the cancellation of clinics when the service was not always meeting the demand for the service. However they told us that they were in consultation with the commissioners regarding the increased demand.

However,

- There was a good incident reporting culture. Feedback was provided and staff met regularly to address how services could be improved.
- The service followed British Association for Sexual Health and HIV (BASHH) Guidance and service audits demonstrated compliance with BASHH guidelines.
- The Faculty of Sexual and Reproductive Health CEU clinical guidelines are accredited by NICE and the service was compliant with these guidelines.
- Staff demonstrated a good understanding of people's needs, ensured they maintained privacy and dignity and took extra time to support people.
- The service worked closely with commissioners to ensure they were targeting local service users; needs.
- The service regularly reviewed the provision it made with other stakeholders to ensure the needs of the community were addressed.
- The service had created multi-agency relationships which ensured service leaders and those within the team were aware of current health economy factors.

Summary of findings

Background to the service

Southport and Ormskirk Hospitals NHS Trust provides sexual health services across the metropolitan borough of Sefton. Services were available from five clinics across the borough and at the main hospital site in Southport. In Sefton there were 273,790 people. Services were provided for all ages. Sexual health services in the five clinics could be accessed on a 'drop in' or appointment basis. At Southport hospital, the service saw more complex genitourinary problems.

In the five clinics, the services provided included all contraceptive methods, sexually transmitted infection testing and treatments including HIV, free condoms and pregnancy tests. In addition, there were referral clinics for psycho-sexual counselling and erectile dysfunction. Community gynaecology was available in South Sefton by GP referral. When possible patients were assessed and treated during the same visit. The clinic service was supported by a clinical outreach service (referral only) and sexual health promotion team.

The sexual health promotion team were responsible for training school nurses, educating vulnerable groups of children and young people, undertaking a sexual health training programme and evaluation of programmes they undertook.

Between February 2015 and January 2016 services were accessed as follows:

West Lancashire Clinics – 4481 visits

Sefton Clinics – 28113 visits

Dept. of Genito Urinary Medicine (GUM) – 806 visits

From 1 April 2016 the West Lancashire service was decommissioned. In Sefton Clinics there were 2084 under 18 attendances for sexual health and 918 under 18 attendances for GUM.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh;

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The service was inspected by a Community Nurse and an Inspector.

Why we carried out this inspection

We inspected this core service as part of our follow up comprehensive inspection of Southport and Ormskirk NHS Hospitals Trust.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 13 April 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

Good practice

All nurses within the service were offered the opportunity to complete the nursing diploma provided by the faculty of sexual and reproductive healthcare.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The service must ensure that staff within the service are up to date with their statutory and mandatory training. (Reg 12(2)(c))
- The service must ensure that all staff have appropriate access to safeguarding information across all clinics including the list of patients where safeguarding concerns have been expressed about them. (Reg 13(2))
- The service must ensure that staff have access to a SPOC during their working hours. (Reg 13(2)).
- The service must ensure all staff within the service are aware of the correct procedure for making a safeguarding referral. (Reg 13(2))
- The service must monitor the responsiveness of the service in respect to the number of patients that are turned away with advice and the cancellation of clinics. Reg 17(2) (a)
- The service should address the patient access to the reception office at the PACE clinic.
- The service should consider introducing a regular record keeping audit.
- The service should improve staff access to IT, policies and procedures in the South Sefton Clinics.
- The service should encourage staff to be aware of the chaperone policy and that patients are routinely offered chaperones.
-

Southport and Ormskirk Hospital NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- The computer system did not consistently flag up patients with safeguarding concerns. Systems in place to address this were not robust across the service's different clinics.
- The number of staff that were up to date with their statutory and mandatory training were below the trust's target.
- Staff did not have access to the internet whilst working in the South Sefton clinics, which had been identified as a concern at the last inspection. The issue prevented the service moving to electronic patient records which presented the service with challenges when service users could access multiple clinic locations without the knowledge of the staff.

However;

- There was a good incident reporting culture. Feedback was provided and staff met regularly to address how services could be improved.
- Medicines were appropriately managed.
- Clinic areas were visibly clean.
- Staff followed best practice guidance when assessing and responding to patients' needs.

Incident reporting, learning and improvement

- Between February 2015 and January 2016 there were 28 incidents in Sefton. 20 (71.4%) were no harm, 4 (14.3%) low harm and 4 (14.3%) near misses.
- Staff told us that they were encouraged to report incidents and that they received feedback.
- The team met monthly to discuss current practice and ways to improve the service. These meetings included reviewing risks and discussion regarding incidents.

Are services safe?

- There were also quarterly governance meetings that included discussion regarding incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of candour was understood by staff we spoke with

Safeguarding

- Southport and Ormskirk Hospital NHS Trust has a duty to safeguard their patients in accordance with the intercollegiate guidance for safeguarding.
- Staff told us that there had been occasions where the computer system had failed to flag up where there were safeguarding concerns. A system had been put in place to help address this issue. However, this did not ensure that different clinics within the service were aware of safeguarding concerns for the same patient. We escalated our concerns regarding this system to service leads. They told us that plans were in place to implement electronic clinical records, which would resolve this issue. This response was provided to us at our last inspection. No implementation date for the new system was provided.
- There were two single point of contact (SPOCs) employed by the trust. They had access to information of concern regarding patients within a list. However, they did not provide cover when all clinics were open. All staff did not have access to the list. Staff told us that if they had concerns, they would speak to the SPOC next time they were both in. We escalated this issue to service leads at the time of our inspection.
- Staff we spoke with knew when they should make a safeguarding alert. However, some staff explained that this needed to be done through the SPOC which is not in accordance with the trust's policy. We escalated this issue at the time of our inspection.
- Across the sexual health service 100% of staff had completed their level three safeguarding children's training. Training levels were monitored by the trust and reported on in the annual safeguarding report.

- Safeguarding arrangements were in place for assessing patients' needs and providing them with access to early help.
- Staff used a proforma document, created by BASHH (British Association for sexual health and HIV) and Brooke Hospital, for assessment, which prompted them regarding safeguarding issues.
- Monthly safeguarding meetings were held to monitor and escalate any new or on-going concerns.
- Staff had access to safeguarding supervision. All the staff we spoke with could identify the Single Point of Contact (SPOC) within the service.
- Information regarding safeguarding concerns were shared at multi-agency meetings.
- The staff we spoke with were all aware of the trust's Female Genital Mutilation policy and knew who to contact to escalate any concerns too. At the time of our inspection a formal pathway was being created.
- Arrangements were in place to safeguard and refer victims of sexual assault in accordance with BASHH guidance. The service had a pathway in place for Child Sexual Exploitation (CSE).

Medicines

- The team had eight trained nurse prescribers.
- Stored medicines were checked on each shift.
- Patient group directions (PGD) were used by the sexual health team. We reviewed the documentation for the PGD which was in date and completed.

Environment and equipment

- The rooms used by the clinics within the service were also used by other services. The trust did not own the premises. This meant that measures that could be undertaken by the trust to help maintain patients' confidentiality were restricted. However, in one clinic staff told us that where patients requested more confidential discussion they would be invited into the reception office. Patient records were stored within this area. This action therefore represented a data protection risk. We escalated our concerns regarding this issue at the time of our inspection.

Are services safe?

- Appropriate arrangements were in place for managing waste and handling clinical specimens.

Quality of records

- The service were aware of the challenges of continuing to rely on paper based records. This risk was recorded on the risk register.
- We saw that notes and files were held securely.
- Staff within the service told us that records had never been audited. We requested confirmation of this from the trust and were told there has no record keeping audit in community in the past 2 years. However, the trust told us that this was in the process of being included in the Trust audit plan.

Cleanliness, infection control and hygiene

- Clinic areas that we visited were visibly clean and maintained.
- Hand gel dispensers were located in various places around the building. Staff had access to personal protective equipment and was seen being used.
- 72.7% of staff within the sexual health service had completed up to date training for hand hygiene. This was below the trust target and of 90%. At the time of our inspection staff were observed washing their hands correctly.

Mandatory training

- At this trust the mandatory training is split into statutory and mandatory training. For statutory training 84.9% of staff had completed their competencies. This did not meet the trust's target of 90%
- For mandatory training 71.2% of staff had completed their competencies. This did not meet the trust's target of 90%
- Staff had received an annual appraisal and felt more supported regarding their professional development.

Assessing and responding to patient risk

- Staff used an assessment proforma, designed by BASHH and Brooke, to assess each patient. This document helped staff to risk assess each patient that presented to them and is in accordance with national guidance "Spotting the Signs".
- Patients had access to clinicians in different clinics at different times of the day from Monday to Saturday.
- The service worked closely with partners to deliver other services such as community condom distribution for people under 19 and community HIV support.
- The website informs the public about all the sexual health services available. Maps and contact details are provided along with clinic opening times and advice.

Staffing levels and caseload

- Staff were available during the week and on Saturdays.
- Staff continued to express concern regarding patients being able to access the service. We asked the service for evidence of the numbers of patients that were turned away with advice/ signposted to another service. Service leads told us that the service did not routinely collect this information. Patients who accessed the service in an emergency were not turned away. However, staff told us that this meant that they often worked late. They could not give us a definitive number of times this had happened. However, the mystery shopper review undertaken did also confirm these findings.
- Staff had designated bases throughout the community but also worked from any base to provide cover when needed.

At the time of our inspection there was 1.12 WTE vacancies within the team. The service were recruiting to 0.8WTE of these vacancies.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Summary

We rated effective as good because:

- The team were actively engaged with regional and national networks.
- The service made use of the internet and facebook to provide information regarding sexual health issues.
- The service had competency packs in place.
- There was evidence of good multi-disciplinary team working.
- The service used nationally recommended guidance to help them ensure appropriate decisions were made regarding consent.

However;

Staff did not have access to the trust's policies and procedures whilst working in the South Sefton clinics. The issue with the internet service provided had not been resolved in a timely manner as it was still ongoing at our last inspection. The issue prevented the service moving to electronic patient records.

Evidence based care and treatment

- The team were actively engaged with regional and national networks.
- The service follows BASHH Guidance and service audits demonstrated compliance with BASHH guidelines.
- The Faculty of Sexual and Reproductive Health CEU clinical guidelines are accredited by NICE and the service was compliant with these guidelines.
- Audits were undertaken across a range of areas including emergency contraception, HIV care and progesterone implants.
-

Technology and telemedicine

- The service did not use telemedicine.
- The internet site provided detailed access information.

- The service had a facebook page which detailed upcoming clinics and health promotion events. Advice was also provided on there regarding sexual assault, domestic violence and giving consent.

Patient outcomes

- The service monitored patients outcomes and discussed them at monthly governance meetings.
- The service used a range of care pathways to ensure patients received appropriate care.
- The sexual health team offered a confidential service.
- Individual case notes were kept up to date to document the choice of contraception, plan of care and treatment choices.
- We saw evidence that there was a clear approach to monitoring, auditing and benchmarking the quality of the services and the outcomes for people receiving care and treatment for example we reviewed audit findings and saw evidence of actions from the audit in place at the time of our inspection.

Competent staff

- There were competency packs in place for specific conditions e.g. cryotherapy. Staff all told us they were up to date with their cryotherapy training.
- The service had funded 23/25 nurses for the nursing diploma provided by the faculty of sexual and reproductive healthcare.
- The service had six faculty of sexual health trainers within the team.
- Staff received safeguarding (including child sexual exploitation and FGM) training annually.
- Staff held group discussions to facilitate learning.
- The service held quarterly education meetings for the whole service. These meetings were scenario based.

Multi-disciplinary working and coordinated care pathways

Are services effective?

- The outreach team supported the pregnancy advisory service by offering sexual health advice to all people who had had a termination.
- The team had a good working relationship with safeguarding teams in other organisations.
- The clinical outreach team worked closely with organisations that supported individuals with additional needs.
- Staff described their relationship with the CAMHS team positively. They felt supported in making referrals and consistently received feedback.

Referral, transfer, discharge and transition

- The clinical outreach team managed a range of vulnerable individuals who could not access mainstream sexual health services. Referrals were accepted from health professionals, GPs and other team members.
- This team supported 'looked after' children to help them make informed decisions regarding relationships.
- The sexual health promotion team provided education and training. They also had access to a resource library for sexual health.

Access to information

- In some of the health centres (South Sefton), staff could not access the trust's policies and procedures due to an issue with the network connecting to the trust's server. Clinic lists were unable to be printed. The issue also meant that there was a delay with the service converting to electronic patient records. This issue was logged on the trust's risk register. However, the issues had been ongoing since 2014.

Consent

- The sexual health team used a proforma which acted as a prompt regarding Gillick competence and Fraser guidelines. This helped to ensure that children's capability to make their own decisions and understanding of the implications of their decisions could be assessed. Service staff could then make appropriate decisions regarding whether treatment provision should be given to these patients without parental consent.
- The team offered a confidential service. Young people gave verbal consent to treatment and advice.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- Staff demonstrated a good understanding of people's needs, ensured they maintained privacy and dignity and took extra time to support people.
- Support materials were in place to help people with additional needs.
- Staff signposted people to other support services when appropriate.

Compassionate care

- Staff we spoke with demonstrated a good understanding of people's personal, cultural, social and religious needs.
- Staff endeavoured to ensure that they maintained patients' privacy and dignity.

- Staff gave us examples of cases where they had demonstrated that they had taken extra time to interact with patients ensuring they met patients' needs.

Understanding and involvement of patients and those close to them

- The service had developed easy-to-read literature and diagrams to support people with additional needs.
- The website and "facebook" page enabled people to understand about sexual health related issues and the availability of clinics.

Emotional support

- The team provided emotional support for young people and provided them with guidance to make relationship choices.
- Arrangements were in place to refer people for psycho-sexual counselling and to other support services e.g. HIV support.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsive as requires improvement because:

- Staff told us two to three times a week people were turned away from the clinics due to the demand and available clinical time. The service did not routinely record the number of patients that were routinely turned away or review it. Whilst these patients were triaged and given advice or signposted to an alternate service, this meant timely access to treatment was not consistently available.
- Staff did not consistently offer a chaperone to patients who were having intimate examinations.
- There were 168 clinics cancelled in the year to January 2016

However;

- The service worked closely with commissioners to ensure they were targeting local service users; needs.
- The staff said they had good working relationships with other service providers which helped facilitate services working to meet the needs of the local population.
- Staff worked closely with patients with additional needs who could not access mainstream sexual health provision to ensure these service users' needs were addressed.
- A sexual health promotion team provided education and training.

Planning and delivering services which meet people's needs

- The service worked closely with commissioners to ensure they were targeting the priorities outlined in the JSNA (Joint Strategic Needs Assessment) e.g. CSE.
- The service worked closely with CAMHS, social care providers and education providers to address the needs of the local population e.g. training school nurses.
- The clinical outreach team worked with individuals and groups who could not access mainstream sexual health services.
- The service used mystery shoppers to ensure they were delivering services that met individuals' needs. The

young mystery shoppers were briefed to undertake a review of all sexual health service provision in accordance with the 'You're Welcome' Department of Health framework.

- The health promotion team did a monthly newsletter to keep people informed.
- A sexual health promotion team provided education and training.
- Advice lines were advertised to support people to seek help and support.

Equality and diversity

- The clinical outreach team worked with individuals and groups who could not access mainstream sexual health services.
- Staff had access to interpretation services and could also book translators to attend in person.
- The buildings were accessible to those with mobility problems.

Meeting the needs of people in vulnerable circumstances

- The clinical outreach team took referrals for vulnerable individuals who could not access mainstream sexual health services. A sexual health promotion team provided education and training.
- The clinical outreach team supported 'looked after children' to make decisions about relationship choices, skills and knowledge.
- The service had introduced a patient passport for patients with additional needs.
- The trust had a chaperone policy. However, staff we spoke with were not aware of the policy content. Staff did not routinely offer patients the option of a chaperone. The proforma that staff completed did not include a question regarding a chaperone. We escalated this issue to the trust at the time of our inspection.

Access to the right care at the right time

- Staff told us that patients were frequently kept waiting for lengthy periods. They said that two to three times a week clinics would get busy to a point where staff could not see any more patients. When this happened staff

Are services responsive to people's needs?

would work beyond their hours, patients would be triaged and when they could not be seen would be given advice or signposted to other services. Staff did not incident report this.

- At the time of our inspection there were no queues at the three clinics we attended.
- We reviewed the report provided by Sefton CVS, a mystery shopper group. This confirmed what staff had told us in that clinics at more accessible times for young people (e.g. evenings and weekends) were frequently too busy and had patients walking away due to the wait times.
- We asked the trust for information regarding the number of clinic cancellations there were and also if they recorded the number of patients who were turned away with advice or signposted to another service. The trust told us they did routinely record the number of patients that were turned away.
- Staff told us that clinics were only cancelled when it was absolutely necessary. 168 clinics were cancelled between 1st February 2015 and 31st January 2016. The main reasons listed for the cancellations were nursing reasons, bank holidays and annual leave.

- Staff told us that where there were lengthy delays, patients were informed of this when they booked in. At the clinics we attended there were also notice boards advising people about wait times.
- Patients had access to a range of clinics at different times. The website detailed when these clinics were available.
- Referral to specialist clinics was available and could be arranged with the assistance of the support network the team had established.
- Whilst there was no specific bariatric equipment available, staff said that the last time a bariatric patient had been turned away was in 2004.

Learning from complaints and concerns

- Between February 2015 and January 2016 the service received two complaints. Both of these were complaints were upheld. Action plans were put in place after the complaints had occurred to ensure that learning resulted from them.
- Staff were aware of the complaints procedure and how to signpost people to PALS.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well led as requires improvement because:

- The management team did not monitor, audit or investigate the numbers of patients turned away from the service due to lack of capacity and so potential risks were unknown.
- Incidents of cancelled clinics and patients being turned away from busy clinics were not reported as incidents.
- The service had a risk register which was reviewed by the trust board. This did not include all risks that the service experienced including the increased demand on services and risk of patients being turned away.

However

- The service regularly reviewed the provision it made with other stakeholders to ensure the service needs of the community were addressed.
- The service had created multi-agency relationships which ensured service leaders and those within the team were aware of current health economy factors.
- All staff within the service were aware of the governance arrangements within the team.
- Staff within the service were collectively responsible for service provision. Staff knew each others professional backgrounds and therefore knew who to contact for advice.

Service vision and strategy

- The team were all aware that their aim was to provide the best integrated sexual health care possible.
- Most staff were aware of the trust's vision.

Governance, risk management and quality measurement

- All staff we spoke with were aware of the governance arrangements within the team. Staff knew how information was shared and where to locate further advice.
- The service had clinical governance meetings on a bi-monthly basis. There were also monthly meetings discussing incidents, the risk register and any matters arising.

- Service leaders shared information to staff in clinics via meetings, the newsletter (which was emailed to all staff on a monthly basis) or on a read and sign basis.
- The team had regular education meetings.
- The service sought feedback from members of the public using surveys. The service also used mystery shoppers.
- The service had a risk register which was reviewed by the trust board and service leads. This did not include all risks the service were experiencing.
- There were clear lines of accountability within the service.
- The numbers of patients turned away from clinics due to the lack of capacity versus the demand was not available to the inspection team as it was not recorded and therefore not well managed.
- Incidents of patients being turned away from busy clinics were not reported and potential risks were therefore not identified or addressed.

Leadership of this service

- Staff told us they knew who to approach to seek advice and guidance.
- Service leaders were described as approachable.
- Service leaders were aware of most of the current issues within the service including issues with the volume of patients were seen. They were working closely with commissioners regarding the business plan and looking to address key performance indicators in line with the services increased demand. However, service leads did not have a comprehensive understanding of the full demand for their services as staff within the service did not log the number of patients who were turned away.

Culture within this service

- Staff we spoke with felt valued and respected.
- The service was centred on the needs of local people and improving their sexual health understanding.

Public engagement

- The service undertook an annual survey where feedback was sought from patients. Feedback showed improvements in patients feeling more welcomed to the

Are services well-led?

clinic than in 2013; improved scores in relation to confidentiality being explained; a reduction in the number of patients who felt able to speak to receptionists without conversations being overheard and an improvement in patients feeling that staff listened to them.

- The service also used mystery shoppers who visited the service and provided feedback. This feedback was used alongside the annual survey and fed back to staff then service improvements could be considered.
- The service had a "facebook" page which provided a range of information about clinics, information regarding sexual health and details of health promotion events.

Staff engagement

- A staff newsletter was shared on a monthly basis.
- The health promotion team did a monthly newsletter to keep staff informed of events they were holding.

Innovation, improvement and sustainability

- The service had increased the number of nurse prescribers.
- At the time of our inspection, the number of clinics had recently been reduced as West Lancashire clinics had transferred to another provider. Service leaders were working closely with commissioners regarding the business plan and looking to address key performance indicators in line with the services increased demand.

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

Diagnostic and screening procedures
Family planning services
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Safe Care and Treatment

People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because of inadequate levels of mandatory training. Regulation 12 (2) (c).

Regulated activity

Diagnostic and screening procedures
Family planning services
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse and improper treatment

People who use services and others were not protected against the risks associated with unsafe or unsuitable systems and processes being established and operated effectively to prevent abuse of service users. Regulation 13 (2)

Regulated activity

Diagnostic and screening procedures
Family planning services
Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must have systems to assess, monitor and improve the quality and safety of services provided.