The Princess Royal Hospital

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Ratings

Overall rating for this hospital	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

Summary of findings

Overall summary of services at The Princess Royal Hospital

Inadequate  

Our rating of services stayed the same. We rated them as inadequate because:

During this inspection we used our focused inspection methodology. We did not cover all key lines of enquiry. We have rated the service as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. Our enforcement action included the use of our urgent enforcement powers where we placed conditions on the trust's registration in relation to the assessment and management of risk, care planning, and incident management. We also served two warning notices to the trust requiring them to make improvements in the following areas; end of life care staffing, end of life staff competencies, end of life governance systems and the way the staff support patients in line with their personal preferences and individual needs.

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.
- The service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.
- Staff did not consistently support patients who lacked capacity to make their own decisions.
- The end of life care service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This had not improved since the last inspection and was identified at our inspection in 2018.
- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.
- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.
- Leaders did not demonstrate that they had the skills and abilities to run the services. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The culture of the services was not centred on the needs and experience of patients.
- The services did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.
- Staff did not always complete risk assessments for each patient in a prompt manner. Action was not always taken to remove or minimise risks to patient's health and wellbeing. Safety incidents were not always managed well to protect patients from avoidable harm. This had not improved since the last inspection.

Medical care (including older people's care)

Inadequate ➔➔

Summary of this service

Our overall rating of this service stayed the same. We rated it as inadequate because:

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This had not improved since the last inspection.
- Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This had not improved since the last inspection. However, records were stored securely and easily available to all staff providing care.
- The service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- The service did not ensure that all staff were competent for their roles. This had not improved since the last inspection.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted. This had not improved since the last inspection.
- The service did not take into account the individual needs and preferences of patients. This had not improved since the last inspection.
- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

Is the service safe?

Inadequate ➔➔

Our rating of safe stayed the same. We rated it as inadequate because:

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. This had not improved since the last inspection.
- Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. This had not improved since the last inspection. However, records were stored securely and easily available to all staff providing care.

Medical care (including older people's care)

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 

Our rating of effective stayed the same. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted. This had not improved since the last inspection.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The service did not take into account the individual needs and preferences of patients. This had not improved since the last inspection.

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate because:

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

Detailed findings from this inspection

Is the service safe?

Assessing and responding to patient risk

Medical care (including older people's care)

Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. This had not improved since the last inspection.

The service continued not to complete holistic and effective falls assessments and falls mitigation plans in line with national guidance which placed patients at serious risk of harm. Six of the 12 falls assessments we reviewed were not fully completed, meaning six patients were not appropriately protected from the risk of harm from falling. One of the patients whose falls assessment and mitigation plan was not fully completed had experienced an inpatient fall on ward 10 and experienced harm as a result of this fall.

Staff did not have access to the information they needed to protect patients from the risk of falling. We found that when a risk of falling had been identified, the plans to reduce the risk of harm were not formally recorded in patient records or nursing handover documentation, so some staff were unable to tell us how they kept this cohort of patients safe. For example, a nurse on ward 10 told us a patient who had fallen on the ward required one to one continuous supervision from a member of staff. We asked the staff member who was in the bay where this patient was located how they kept that patient safe and they told us they were not aware that the patient required one to one supervision.

Staff did not manage the risks associated with bed rails which placed people at risk of serious harm. We found that bed rails were used when contraindicated in five of the 12 bed rail assessments we reviewed. In one of these examples, a patient who was acutely confused which is a significant contraindication in the use of bed rails, fell from their bed when bed rails were in situ. This resulted in injury to the patient.

The service continued not to ensure patients were protected from the risk of developing pressure ulcers. Four of the 12 pressure care assessments we reviewed showed patients had evidence of high to very high risk of skin damage. Nursing records also evidenced that these four patients had skin damage ranging from category one to three pressure ulcers. Despite this, none of the four patient's records contained a patient specific skin care plan that detailed how staff should monitor and treat their skin. This meant patients were at risk of suffering a preventable deterioration in their skin.

The service continued not to effectively assess and plan for the risks associated with behaviours that challenged. These behaviours included agitation and aggression. This placed patients and staff at risk of serious harm. Five of the 12 full patient records we reviewed showed that patients with behaviours that challenged had no care plans in place to guide staff on how to safely respond to these behaviours.

The service did not effectively assess and plan for the risks associated with pre-existing conditions that patients were admitted with, placing patients at risk of harm or a deterioration in their pre-existing medical condition(s). For example, two of the patient's whose care we reviewed were admitted to hospital with respiratory conditions that required specialist equipment and treatment. Neither of the care plans for these two patients contained risk assessments or care plans relating to their respiratory conditions. As a result, staff were unable to tell us and care records failed to show if the equipment one of these patients was admitted with to enable them to breathe effectively was used during their inpatient stay. The other patient's condition meant they were at serious risk of harm if their surgical airway (tracheostomy) became blocked. The emergency equipment required in the event of an airway blockage was not available on the ward and staff did not know this was required. After we raised this with staff they did obtain an emergency tracheostomy care kit for the ward. However, the staff member responsible for this patient's care at that time told us they had not been trained to use the kit.

Nursing staff displayed a lack of accountability with regards to their role in assessing and managing patient risk. For example, when we asked a staff member why a patient's care plan did not contain risk assessment and management for their respiratory equipment needs. They told us this should have been completed by the nurse in the acute medical unit. They did not acknowledge their role in assessing and managing this risk as the patient was now their patient on their ward.

Records

Medical care (including older people's care)

Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. This had not improved since the last inspection. However, records were stored securely and easily available to all staff providing care.

Assessments contained in the nursing documentation were not always completed to ascertain patients' individual needs. Five of the 12 assessment documentation we reviewed contained significant gaps in these assessments. The gaps included important areas of care, such as; vision, hearing, bowel and urological patterns and history and social history. All of which is essential to provide safe, effective and responsive care. This meant patients were at risk of receiving care and treatment that did not reflect their needs.

The service continued not to ensure that the information needed to guide staff in how to provide safe and consistent care was available as the relevant generic care plan options contained within the nursing documentation were not highlighted to show the care each patient required. None of the 12 patient generic care plans we reviewed highlighted the care and treatment each of the 12 patients required to meet their needs. This meant patients were at risk of receiving unsafe and inconsistent care that was not in line with their individual needs.

Patient repositioning charts were not always completed fully to outline patients individual repositioning needs. Four of the 12 patients who were identified as at high or very high risk of skin damage had incomplete repositioning charts in place. This meant we could not be assured that patients were being supported to change their position at a frequency that was in line with their individual needs and best practice guidance.

Daily top to toe skin assessments were recorded for all patients who received assistance with personal care assistance from staff. However, these assessments were not completed accurately so did not effectively record the condition of individual patient's skin. Where wounds were present, this documentation also lacked detail as to the size and depth of the wound. This meant that a nurse could not assess if patient's skin was improving or deteriorating.

We found that where catheters were used, catheter care plans or passports were not in place to record when the catheter should be reviewed or changed. We reviewed the records of two patients on ward 10 who had urinary catheters insitu. We found that accurate records detailing the reason for catheterisation and catheter review dates were not always completed for both patients. For example, the records of one of these patients showed they had a catheter insitu for nine days, however, on eight of these nine days the documentation that should have showed the reason for catheterisation and review date was blank. This meant the information needed to guide staff on how to provide safe catheter care was not always available, placing patients at risk of unsafe care.

We found that records did not contain an accurate account of the care patients had received. For example, on ward 10 the falls documentation had been signed by staff to show that lying to standing blood pressure readings had been taken. However, staff were unable to evidence that these blood pressure readings had been taken as these readings were not recorded in the patients' records.

The staff continued not to always follow the trust and their professional bodies best practice guidance for record keeping. It was not always clear which staff had assessed and treated patients as records did not always contain a clear record of the staff members name and role who had completed the written entry. Dates and times of written entries were also not consistently recorded to demonstrate an accurate timeline of patients' care.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Medical care (including older people's care)

This inspection was triggered by a never event that had occurred on a medical ward at the Royal Shrewsbury Hospital site. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Following the never event, the trust told us that a patient safety alert had been sent to staff to highlight the never event and share learning to prevent a similar incident from reoccurring. We asked 13 members of staff on wards nine and 10 if they were aware of the recent never event.

Only one of the 13 members of staff were aware of the incident and the learning from it. This meant that the systems in place to manage safety incidents were not always effective.

We found that staff did not identify the safety concerns we identified as incidents. Therefore, these incidents were not reported. For example, the lack of appropriate risk assessment and management plans and the poor record keeping were not reported as incidents. This meant learning from these incidents could not take place to improve safety and care.

Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We found that the trust's falls and pressure ulcer policy was not based on the most up to date national guidance.The trust's, 'Slips, Trips and Falls Policy' which was last updated and approved in February 2020 continued to reference the National Institute for Health and Care Excellence (NICE) falls guidance for older people from 2004. This guidance has been replaced and the latest NICE guidance recommends that falls prediction tools are no longer used to identify if older people are at risk of falling. These prediction tools should have been replaced with multifactorial assessments for all patients who are 65 and over. We found that this new guidance was not being followed to ensure all patients aged 65 and over had a multifactorial falls assessment and intervention plan.

The trust's, 'Pressure Ulcer Prevention and Management Policy' which was last updated in February 2019 following the February 2019 NICE update. However, we found that this policy did not fully reflect best practice. For example, the need to consider all pressure ulcers as potential serious incidents dependent upon individual circumstances. The policy referred to only reporting grade three and four pressure ulcers as serious incidents. The policy does not reflect that a grade two pressure ulcer could meet the serious incident reporting criteria under certain circumstances. This meant NHS England serious incident guidance was not accurately incorporated into the policy.

Competent staff

The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.

On ward nine a nurse responsible for the care of a patient with a tracheostomy told us they had not been trained to use the emergency tracheostomy care kit. This placed that patient at significant risk of harm in the event of a medical emergency involving their tracheostomy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted. This had not improved since the last inspection.

Medical care (including older people's care)

Staff continued to not always follow the requirements of the Mental Capacity act 2005 (MCA) to ensure decisions about care and treatment were made in patient's best interests when they were unable to make these decisions for themselves. On ward 10 we saw two patients were receiving

sedative medicines to control and restrict their behaviours. No mental capacity assessment or best interest decisions were completed to ensure this treatment was in their best interests.

The service continued to not consistently ensure that patients were only deprived of their liberty in line with the Deprivation of Liberty Safeguards (DoLS). We found that a patient on ward nine and a patient on ward 10 were both being unlawfully deprived of their liberty. Both patients were acutely confused and unable to make decisions about their care and treatment and both were prevented from moving freely around their wards. Neither patient had a DoLS application in place or in progress.

On ward 10, two of the patient records we reviewed contained DoLS applications which showed staff had completed appropriate applications. However, one of these patients had previously been admitted to the ward in May 2020. Records from that admission showed there was a four-day delay in applying for their DoLS which meant they were unlawfully restricted for a four-day period. We also saw that the mental capacity assessment required for the DoLS was completed the day after the DoLS application was made. This meant that the requirements of the MCA and DoLS were not consistently followed correctly and in a timely manner.

Staff continued to inform us they had not completed training in MCA and DoLS. For example, only one of the six staff members we spoke with on ward nine told us they had completed this training. Staff on this ward told us they would seek advice from their ward manager if they suspected a patient required a DoLS application. However, at the time of our inspection, the ward manager on ward nine had not been in work for a four-week period. This meant that at the time of our inspection, the support system staff described to us on ward nine around DoLS was not effective.

Is the service responsive?

Meeting people's individual needs

The service did not take into account the individual needs and preferences of patients. This had not improved since the last inspection.

Patients continued to be at risk of receiving care and treatment that was not person centred as assessments to ascertain patients' care preferences and individual needs were not completed. None of the 12 care assessment and care plans we reviewed contained any record of patients care preferences or individual care needs. For example, the care records for five patients who displayed behaviours that challenged, such as agitation and aggression, contained no information about their likes or interests that could be utilised to help staff manage these behaviours in an effective manner.

The service continued to not support patient's with acute confusion to be orientated to time and place. For example, on ward 10 we saw that two patients with acute confusion were located in a

bay where the orientation board was not updated. The month on the board stated it was May which meant staff had not updated the board for at least 10 days.

The preferences of patients at risk of falling were not always considered. The falls prevention practitioner told us they were aware that these patients were often nursed in bed. On ward 10, we saw a patient that was at risk of falling attempting to stand up from their chair. The member of staff did not attempt to find out why the patient wanted to stand up but instead insisted the patient sat back down. This demonstrated a lack of understanding of the patient's needs and a lack of application of a person-centred approach.

Medical care (including older people's care)

Is the service well-led?

Leadership

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

Many of the concerns we identified at this inspection were ongoing concerns that had been identified at previous inspections and had not been effectively addressed. For example, we reported concerns with the lack of effective falls risk assessment and mitigation plans at our 2018 and 2019 inspections. However, leaders had not effectively driven the safety and quality improvements that were required to address this.

Leaders were not always visible or available. Staff on ward nine told us their ward's purpose had significantly changed during the Covid 19 pandemic as it had moved from a predominantly respiratory ward to a short stay admissions ward. They also told us their ward manager had been absent from work for a four-week period and that no interim leadership was put in place to ensure this team were consistently and appropriately supported. This meant the day to day leadership support that staff required was not always available. For example, some ward nine staff told us they would seek advice from their ward manager when they needed advice and support reading DoLS applications. However, this advice could not be sought when the ward manager was absent.

Culture

The culture of the service was not centred on the needs and experience of patients.

We saw that the lack of appropriate risk assessment and care planning had been normalised on the wards we inspected. Staff at all levels did not recognise that this failure to adequately assess and plan patient care led to practice that was unsafe and uncaring.

We found that there was a normalisation of poor care and a complacency around professional curiosity and challenge. For example, nursing staff and allied healthcare professionals did not challenge medical staff when decisions were made about care or did not contain evidence of patient's individual preferences. Furthermore, we found that staff did not challenge one another when they witnessed witnessed poor care or documentation of that care. For example, where body maps,used to highlight areas of pressure damage, were marked with a simple x on the area affected and there was no documentation as to what this meant staff did not challenge their colleagues to complete the document appropriately so that care given could be assessed for impact.

Governance

The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

There was an absence of effective audit of care documentation to ensure the quality of the information contained in care records was person centred and appropriate. For example, action had not been taken to ensure nursing assessments were completed correctly or to ensure care plans were in place to ensure staff had access to the information they needed to keep people safe. Following our inspection, the trust told us they had reintroduced their exemplar ward reviews (the trust's own quality and safety assessment tool). The use of the exemplar ward reviews had been paused due to inspection activity and the Covid 19 pandemic. We will assess if this has been an effective governance tool at our next inspection'

We saw that there was a lack of learning from previous incidents. We spoke to a specialist nurse about the trust's improvement plan following a prosecution of the trust by the Health and Safety Executive in 2017, in regard to patient

falls. Prior to inspecting the trust, we reviewed a number of recent incidents relating to falls at the trust and found the same issues reported as had been highlighted in the prosecution summary judgement. For example, a lack of staffing, poor risk assessments, poor documentation of care and poor falls management. At this inspection we found the same issues on the medical wards were still evident in the care that was given to patients at risk of falling. This compounded our concerns that the trust failed to learn from significant incidents.

The service did not have timely and effective actions in place in their improvement plan to appropriately address all previous inspection findings and concerns. For example, our 2018 and 2019 inspections identified a lack of person-centred care planning. The trust's 2020 action plan recorded an associated action to address this which stated, 'patients must have their individual needs assessed and planned for'. The action plan recorded that this was to be addressed by, 'implementing new nursing documentation to include individual needs'. This action was to be completed by June 2020. Other than introducing new documentation, no other interim action, such as; staff training, care record audits etc had been planned or introduced to address the significant and ongoing shortfalls in patient centred care planning whilst awaiting new documentation to be rolled out.

Areas for improvement

The trust must:

Ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, pressure care, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.

Ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. Regulation 17 (1)(2)(c): Good governance

Ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

Ensure staff are competent in their roles. This includes but is not limited to the use of; equipment to meet individual needs and care planning. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.

Ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.

Ensure that people are only deprived of their liberty in a lawful manner, by following the deprivation of Liberty Safeguards. Regulation 13(5) Safeguarding service users from abuse and improper treatment.

Ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including needs relevant to the formulation of care plans and mental health needs where appropriate. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.

Ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance.

The trust should:

Review the systems in place to ensure staff are consistently supported in the absence of a ward manager.

End of life care

Inadequate 

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.
- The service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.
- Staff did not consistently support patients who lacked capacity to make their own decisions.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This had not improved since the last inspection and was identified at our inspection in 2018.
- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.
- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.
- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate because:

- Although the service had enough suitable equipment to help them care for patients it was unclear if these were available in a timely manner.
- Staff did not consistently complete and updated risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.
- The service did not have enough nursing and support staff to keep patients safe.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not always have a consultant on call during evenings and weekends. Staff could telephone a local hospice for advice and support. However, there was no formalised agreement for this in place.

End of life care

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 

Our rating of effective stayed the same. We rated it as inadequate because:

- Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.
- The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.
- Key services were not available seven days a week to support timely patient care.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

Our rating of caring CHOOSE A PHRASE. We rated it as CHOOSE A RATING because:

Our rating of responsive CHOOSE A PHRASE. We rated it as CHOOSE A RATING because:

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.
- Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

End of life care

Detailed findings from this inspection

Is the service safe?

At the time of our inspection, there was no dedicated end of life care ward at the trust. Patients in receipt of end of life care were cared for throughout the hospital.Prior to 05 June 2020 the trust did have an end of life care ward but this had been closed due to the realignment of the wards to accommodate Covid 19 arrangements.

Environment and equipment

Although the service had enough suitable equipment to helpto care for patients it was unclear if these were available in a timely manner.

The service used specialist syringe pumps for patients who required a continuous infusion of medication to help control their symptoms. These met the current requirements of the Medicines and Healthcare Regulatory Agency (MHRA) for end of life care patients who required continuous symptom management. On review of the incidents reported this year we noted three relating to the delay in providing patents with a syringe pump for medications to be given resulting in a potential delay in pain relieving medication being given.

Assessing and responding to patient risk

Staff did not consistently complete and updated risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.

We discussed how patients wishes were reflected on the end of life care pathway with the specialist team. We were told that this aspect of the ReSPECT form was not well completed and that this information would be captured on the end of life care plan for patients at the end of their life. However, minutes of meetings reviewed demonstrated that the use of this tool was only 30%.

We found that patients end of life care preferences had not always been recorded in accordance with local and national guidance. Five of the nine ReSPECT forms we reviewed contained no record of the patient's end of life care preferences.

The service continued to not have an effective system in place to track patients who were in receipt of palliative care or end of their life care. This meant these patients were at risk of not receiving care appropriate to their needs.

We received one complaint about care provided to an end of life care patient from this hospital. This complaint included the fact that staff did not listen to the patient and provide for their individual needs at the end of their life.

Nurse staffing

The service did not have enough nursing and support staff to keep patients safe.

End of life care was provided by an end of life care team. The service also had a specialist palliative care team. These teams worked throughout the Princess Royal Hospital and the Royal Shrewsbury Hospital.

The end of life care team consisted of a whole time equivalent (WTE) end of life care facilitator and three end of life care nurses who provided the equivalent of 1.8 (WTE) staff. The end of life covered across sites from 8.30am to 16.30am Monday to Friday. Out of hours cover was provide through an on-call service at a local hospice.

The specialist palliative care team consisted of four clinical nurse specialists (CNS) who provided the equivalent of 3.8 WTE cover for the specialist palliative care team. The four nurses worked across sites and provided a service Monday to Friday from 9am to 5pm.

End of life care

Nurse staffing levels did not meet the minimum standards of the National Institute of Health and Care Excellence (NICE) which states access to specialist palliative care should be made available seven days per week.

There were no specific handovers from the specialist palliative care team (SPCT) and the end of life care team to the nursing and medical staff.

At our inspection in November 2019 we found breaches in staffing levels not in line with guidance from the National Institute of Health and Care Excellence. However, the trust's most recent action plan, received 23 July 2020 did not contain updates on the action the service had taken to improve nursing staff levels within the team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have a consultant on call during evenings and weekends.

One palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.8 whole time equivalent (WTE) cover at the trust. This did not meet the minimum standards of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. At the time of our previous inspection, In November 2019, the trust had started the recruitment process to employ a new consultant to provide an extra 0.5 WTE across both sites. This post had still not been recruited into at our June inspection.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

At our previous inspection in November 2019 we were told that since the 2018 inspection the trust had introduced a category for end of life care incidents. This meant relevant staff could identify, track and analyse incidents relating to end of life and palliative care patients. We asked the trust for incidents relating to end of life care from 01 January 2020 to the present date, as on our review we could not see a category for end of life care. The trust sent us details of 14 incidents which had been reviewed as end of life care incidents. We reviewed the incidents submitted to national databases by the hospital and found that no incidents were specifically reported under an end of life care category. However, we found between 1 January and 20 July 2020, we found that there were at least 34 incidents reported involving patients at the end of their life. Eight of these related to poor management of pain, medication or access to syringe drivers. Five incidents related to patients not being transferred to the correct ward and five related to pressure area care. The remaining 16 incidents related to poor care planning.

On review of the spreadsheet sent by the trust all but one of the incidents were incidents that we had reviewed. The spreadsheet had a description of the incident, immediate action taken, details of the investigation and lessons learnt. However, the lessons learnt pertained only to the individual member of staff or patient and the wider lessons had not been identified except in one case where the policy for admission to ward 35 had been amended. Four incidents involved delays in transferring the patient and three related to no support being available to staff. All incidents were graded as low or no harm despite the results being recorded as; delay in diagnosis and treatment, ongoing pain, disruption to the service and no injury, harm or adverse outcome.

This meant the hospital was not monitoring all incidents that occurred within this service. The service was also failing to share the lessons learnt in these incidents with the wider hospital team. The end of life care safety meeting minutes from February 2020 demonstrated that an incident had been discussed at the meeting. However, this was not one on the spreadsheet by the trust. The minutes also highlighted there were issues with staff using the end of life care category when reporting incidents.

End of life care

Is the service effective?

Evidence-based care and treatment

Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.

Managers and staff did not carry out a comprehensive programme of audits to check improvement over time. On reviewing the Quality Improvement plan sent to the CQC in July 2020 the action to establish an audit plan for this service was still in progress.

At our inspection in November 2019 we found that the service recorded patient information onto an electronic data base, including the patients preferred place of death, however, the service did not audit this information. We noted from the results of audits that the trust sampled whether the patients preferred place of death was recorded and how many patients achieved this. However, there was no record of whether all patients achieved their preferred place of care and the time taken to move patients into their preferred place of care. The lack of cohesion between the specialist palliative care team and the end of life care team did not help the movement of patients and information between these two services.

At our inspection in November 2019 we found that the service did not audit pain or symptom control for end of life care patients, this meant the service was unable to tell if pain and symptom control was effective or if improvements could be made for end of life care patients in their care. This had not improved since our last inspection. We received one complaint where a patient had not been prescribed adequate pain relief to meet their needs. The staff did not review the effectiveness of the medication or discuss the medication this patient was on at home and provide this whilst in hospital. This patient was not offered regular analgesia nor was a syringe pump offered to manage their pain. This had not improved since our last inspection.

At our inspection in November 2019 we found that the service did not have a comprehensive audit programme undertaken by the service, which meant that care was not improved as a result. This had not improved since our last inspection. We reviewed the minutes of the End of Life Steering Group for February 2020 and saw that the trust planned to audit mouthcare, care after death and use of syringe pumps. We did not receive any data from the trust on these audits.

The trust confirmed that they had undertaken a “Spot Check on End of Life Care plan”. This audit was undertaken in June 2020. A previous audit was carried out in January 2020 but this does not appear to have been discussed at the February End of Life Safety and Governance Meeting. The audit reviewed seven sets of notes at this location. Due to the way in which the report is collated it was not possible to identify all of the results for this location. The results demonstrated that all patients were on the end of life care plan. Most patients had a ReSPECT form completed prior to being commenced on an End of Life Care Pathway. Four patients out of seven records reviewed did not have a documented conversation with the patient around their preferences for end of life care. However, there was a documented discussion with the family or relatives of the patient in all records. Three sets of records did not have a preferred place of care recorded. Only two of the seven records had all sections of the end of life care plan completed. This was worse than the previous audit. The action to be taken following the audit was to improve compliance through training. However, at the point at which this report was written, March 2020, compliance with the eLearning package was 50%.

The latest data from the National Audit for Care at the End of Life (NACEL) was published on 9 July 2020. The audit presents results against seven themes. For six themes, performance is calculated by aggregating scores from a series of

questions and converted to a score out of 10 for each theme. In comparison against the national average the Princess Royal Hospital seem to perform relatively poorly in three of the four measures they have results for. These include communication with the dying patient, communication with family and others and individualised care planning. In the remaining theme Workforce/specialist palliative care performance is towards the national average.

We reviewed the minutes of the End of Life Steering Group for February 2020 and found the local audit in the use of the service's end of life care plan had increased from 15% to 30%. A further audit was planned around the time of our inspection. This meant that only three out of ten patients who were receiving end of life care had a plan to follow specifically for them at the end of their life. Following the inspection, the trust sent us this audit. This showed that 37% of patients there was uncertainty if the patient would die during this admission and active treatment was continued. Of the notes reviewed only 21% had the palliative care team involved in their care and 9% had the end of life care team involved in their care. This was despite 97% of patients being recognised by staff that they may die and only 6% of patients having had a conversation with staff about the fact that they may die. The audit results reflected that conversations about the patients death was more likely to be had with the patients family or relatives (81%). The audit demonstrates that 30% of patients were placed on the end of life care plan. Only one patient was involved in planning their care at the end of their life. 48% of records reviewed demonstrated that neither the patient nor the family were involved in planning the care at the end of a patient's life. This means that the patient was not involved in their care at the end of their life and did not have the support of specialist nurses.

This audit demonstrates that anticipatory medications were prescribed for around 60% of patients to support their potential discomfort. However, a syringe pump, to assist consistent pain management, was only used in 19% of patients. The preferred place of care was discussed with 30% of patients and carers. In most (90%) cases this was discussed with the patient's carer. In 60% of patients the preferred place of care was not achieved. The free text of this audit highlights that staff are not recognising patients at the end of their life in a timely manner, once recognised there were delays in an end of life pathway being commenced. We were not sent an action plan following this audit to improve the recognition of patients at the end of their lives or in ensuring that they received appropriate care. It is therefore unclear how the trust is planning to improve the care given to patients at the end of their life.

The trust undertook an audit of the completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in January 2020. This demonstrated that:

- The patients' personal preferences for care were only documented 62% of the time.
- Over 30% of clinicians did not give recommendations for emergency care and most did not provide clinical guidance on appropriate interventions.
- In all cases the clinician identified if cardiopulmonary resuscitation (CPR) was recommended and in all but one case the patients were not recommended for CPR.
- Over 90% of ReSPECT forms had section 6 completed but less than half had documented who was involved in the discussion.
- Where a patient was recorded not to have capacity only one patient out of 67 had the appropriate legal documentation to support this decision.

Whilst this audit made recommendations for improvement this was not presented at the Quality Operational Committee until 16 June 2020. However, in discussion with senior executives the outcomes of this audit were known. This meant that we were not assured that actions and learning from audits were implemented in a timely manner to ensure improvements to practice could be made.

End of life care

Following our inspection, the trust sent CQC a Clinical Audit action plan, 24 July 2020, which centred on training and raising awareness of the ReSPECT form and the audit. Eight actions were colour coded green but rated as recommendation never actioned. Three actions were marked as amber, action in progress and one action coloured red and rated as recommendation agreed but not yet actioned. It was difficult to see how the trust had implemented this action plan given that some completion dates were marked as the end of July 2020.

The trust told us that training in the use of the ReSPECT form was incorporated into resuscitation training. Current compliance for this training which is a two year rolling compliance figure is 79%. However, the ReSPECT form was only introduced at the end of October 2019. Therefore, this figure would include staff where this training had not included information on the ReSPECT form. The trust introduced an eLearning package which 257 staff had completed. Furthermore, the lead resuscitation officer had trained 29 people. The end of life care team were not involved the provision of this training.

The trust undertook a bereavement survey between April 2019 and March 2020. This demonstrated that relatives had had discussions with staff about the fact that their loved one may die. However, only 45% of relatives were involved in planning the care with the care staff during the last days of their loved ones life. Most relatives (80%) felt that their loved one had received appropriate care. The survey identified some areas requiring improvement, including discussion with the patient about where they wanted to die (45%), use of the end of life plan (57%) and provision of the information leaflet (23%). It is clear that the relatives of the patient felt that care was appropriate, but this is not reflective of the evidence in the case notes audited by the trust.

Competent staff

The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.

Staff told us they had not received effective training to enable them to use Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) forms in line with national and local guidance. ReSPECT forms are designed to provide a summary of a patient's end of life care wishes which includes resuscitation decisions. ReSPECT forms had been rolled out at the trust in 2019 but no effective and measurable training programme was in place. This meant the trust could not assure themselves or us of how many staff had been trained and were competent in the use of ReSPECT documentation.

On ward seven, the ward manager could not tell us how many staff on the ward had received training to enable them to administer medication to patients at the end of their life through a syringe pump. A syringe pump is a small infusion device that is used to administer a continuous infusion of medication from a syringe. Following our inspection, the trust shared with us the training numbers for syringe pumps up to the date of our inspection. This demonstrated 40% of eligible staff on ward seven had completed this training. However, in some areas, such as ward four, the training compliance rate was 10%. This meant there was a risk that patients may not receive their medication through a syringe driver in a timely manner as not enough staff had been assessed as competent in many of the wards throughout the hospital. Following our inspection, the trust sent CQC an action plan for the training of staff in using the syringe pumps. This highlighted that it would be incorporated into further intravenous study days, reports on training would be made available for the ward managers and train the trainer sessions would continue. The action plan stated that the trust were looking in to providing an eLearning package for staff. It was not clear who had approved this plan.

Seven-day services

Key services were not available seven days a week to support timely patient care.

When we inspected the trust in 2018, we told the trust they should ensure it provided and meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is 9am to 5pm, seven-days per week.

End of life care

We re-inspected the service in November 2019 and found the hours of the service had not increased. This meant the trust was not providing a minimum service level for access to specialist palliative care as recommended by NICE. The trust still only provided nursing staff to offer a specialist palliative care service Monday to Friday from 9am to 5pm. Again, we told the trust it should provide its specialist palliative care services seven days a week in line with NICE guidance.

Following a review of the service in July 2020, we found the service operated between 8.30 and 5pm Monday to Friday with on call support from a local hospice. This lack of seven-day provision was included on the services risk register. The minutes of the end of life care steering group, February 2020, reported that there was no update. However, data was being gathered to support a business case. This had not improved since our previous inspection.

On reviewing the Quality Improvement plan sent to the CQC in July 2020 the action to establish a service level agreement with the hospice was still in progress

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

We found that mental capacity assessments were not always completed in accordance with the Mental Capacity Act (MCA) when patients were unable to make decisions about their end of life care needs. We reviewed seven ReSPECT forms. Four of these forms related to patients who staff told us did not have capacity to make decisions about their care and treatment. However, the records for these four patients contained no evidence to show mental capacity assessments had been completed. This meant that the requirements of the MCA had not been followed to evidence these patients did not have the capacity to make these decisions and that these decisions were made in their best interests.

We discussed how the medical staff assess a patients' mental capacity when completing the ReSPECT form with the specialist nurse. We were told that there was a separate form to complete. We reviewed nine patients, three of whom were deemed to lack capacity to make decisions, however, no formal mental capacity assessment had been completed. A further patient had not indication that their mental capacity had been considered at all. The specialist nurse told us that even when a patient had capacity to make a decision about their care it was good practice to discuss the proposed care with the family in order to ascertain what the patient was like at home or if they had any concerns about the decision of the patient.

Is the service well-led?

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

Leadership

End of life care and specialist palliative care services sat within the division of scheduled care. Scheduled care was led by a medical director, an assistant chief operating officer and a head of nursing.

At board level, the chief nurse and the chair were the executive leads for the end of life care and specialist palliative care services throughout the trust. However, the chief nurse had only just assumed this responsibility and was not aware that the end of life care strategy was in draft format. The end of life care team was directly managed by the matron for oncology and haematology. On reviewing the most up to date Quality Improvement Plan (QIP) for the trust sent in July 2020 the action update in respect of leadership stated that a non-executive director was required to lead this service. Yet this action is marked as completed on the QIP.

End of life care

The executive lead for end of life care did not attend the steering group meetings prior to June 2020 and end of life care was not discussed at the trust's board meetings

Leaders did not effectively introduce new ways of working. For example, the roll out and implementation of the ReSPECT form was not robust which led to staff not having an adequate understanding of this process. Staff told us that despite there being an implementation plan and policy, no resource was allocated for education. Doctors we spoke with told us they received some training through their grand rounds where they reflected on clinical cases. Nurses told us they had received minimal training and did not feel confident in the use of the ReSPECT forms.

Vision and strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.

We were told at our previous inspection that there was an end of life care strategy. We asked the trust for their end of life care strategy and action plan. The strategy was still in draft form and there was no action plan. Staff told us the strategy had been developed approximately 18 months prior to our inspection. This had been taken to the Clinical Governance Executive Group in November 2019 to be endorsed. Minutes of the meeting concurred that an end of life care strategy should be implemented in early 2020 and discussed at the next board meeting. However, at the time of our inspection, the strategy had not been discussed at any board meeting, it had not been endorsed, signed off by the board or implemented.

There were two teams of specialist staff who were responsible to provide specialist knowledge and experience to general staff. The end of life care team supported people who had days or hours of life left. The specialist palliative care that helped staff in the management of patients who had weeks or months of their life left. It was not clear how information form either team was passed between the teams to improve the patient and carer's experience of a dying patient.

Culture

The culture of the service was not centred on the needs and experience of patients.

We found that there was a deference to medical staff held by nursing staff. When we questioned a specialist lead about how patient wishes were captured in respect of resuscitation, we were told that patients cannot demand treatment and that it was the doctor's decision if a patient should be resuscitated. When discussing the poor completion of ceilings of care area on the ReSPECT form we were told that it was everyone's responsibility to complete this. When asked if there was an action plan to address this failing, we were told that during the COVID pandemic that awareness had been highlighted but that the specialist nursing time is limited. This raised concerns around the culture of service. This highlighted the acceptance of poor care and the poor understanding of the ReSPECT form's purpose.

We saw in the patient records we reviewed and the audits from the trust demonstrated that there was a lack of communication between staff and the patient who was dying. Whilst we appreciate that this may not always be possible in the last days and hours of a patients life there was an apparent reluctance to do this. However, most families or carers had been spoken to about the fact that the patient was dying and what their wishes were during this time. When we spoke to the lead nurse we were told that they believed that even when a patient had capacity to make decisions staff should talk to the family to see if they have any concerns or what the patient is usually like. This meant that whilst the family were involved in discussions there was little acknowledgement that the patient may have different wishes to those of their family. There was a culture of not involving the patient in decisions made about their care.

Governance

End of life care

The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

Minutes of the Clinical Governance Executive Group in November 2019 highlighted that there was a lack of medical staff compliance with completion of the end of life care pathway. Patients had been either late to start on the end of life care pathway or they had not commenced this at all. The minutes state that "End of life care is not consistent across all areas and it is important that everyone delivers. The action pertaining to these comments was to check what training had been delivered and report back. However, in subsequent minutes there was no further update. This was corroborated in the Healthwatch End of Life Report, January 2020, which stated that people had a poor experience until the care staff at the hospital recognised that the patient was at the end of their life when the experience improved.

We reviewed the minutes of the End of Life Steering Group for December 2019 and February 2020 and found that whilst there was some improvement between December 2019 and February 2020 on the training of medical staff to address the medical staff completion of the end of life care pathway and the ReSPECT forms there was little traction on other issues discussed at these meetings.

The service continued not to take timely and effective action in response to quality and safety audits where concerns or poor compliance was identified. For example, effective action had not been taken in response to an audit of ReSPECT documentation completed in January 2020. At the time of our inspection, four months had lapsed, and the senior leadership team had been aware of the results of the ReSPECT audit but had taken no action to make improvements in its application.

Action plans sent by the trust following our inspection were not clear as to whether action had been taken or embedded. The Clinical Audit Action plan updated 21 July 2020 had items listed as being complete but had a rating of 4 which meant recommendation never actioned. This document also had actions such as roll out of training which had commenced but had not been fully embedded having only started in June or July. The Quality Improvement Plan, updated in July 2020, stated that there was a requirement for a non-executive end of life care lead but the chair told us it was him at our inspection in June 2020.

The trust told us that they had had nine complaints since January 2020 in respect of the end of life care service of which three related to the Princess Royal Hospital. The themes from these complaints included poor communication with the family, delays in medication and poor communication around resuscitation.

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

The current risk register for end of life care had three risks on it. These were in relation to training around the mental capacity act and deprivation of liberty safeguards, the provision of specialist consultant input and the risk that the end of life care and palliative care team were not sufficient to meet the needs of patients. When we asked for the detail of these risks we were provided with only two risks the sufficiency of the service to meet demand had been on the risk register since April 2019 and had not been updated since November 2019. The shortage of specialist consultant staff had last been updated in November 2019 and interviews were due to take place in January. However, at the time of our inspection there was no new appointee in place. The risk in relation to training around the mental capacity act and deprivation of liberty safeguards was not on this "detailed" information. There were no risks related to auditing or training on specific end of life care issues.

The trust failed to act on the risks following audits. We noted that a number of audit results were available but that these were not acted upon in a timely manner within this service. Examples of this includes the audit of completion of the ReSPECT form and the audit on the completion of the end of life care pathway. This meant that whilst the trust was in receipt of information on the risks held by the service this was not used to improve services in timely manner.

End of life care

Areas for improvement

The trust must:

- The service must ensure staff are competent in their roles. This includes but is not limited to the use of the completion of ReSPECT forms and the use of syringe pumps. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.
- The service must ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted on the ReSPECT forms. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.
- The service must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance
- The service must ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.
- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the governance processes. Regulation 17(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

Our inspection team

The inspection team consisted of a head of inspection, two inspection managers and four inspectors.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment