HMP YOI Chelmsford Prison

Quality Report

200 Springfield Road
Chelmsford
Essex
CM2 6LQ
Tel:
Website:

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

Summary of this inspection

Detailed findings from this inspection

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect the safe domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 24 August 2016.

- There was an established system for reporting and recording significant events. Since our last inspection in April 2016 there had been an increase in reported incidents. Staff were aware of how to report incidents and we were told that there was now an open culture across the service in respect of reporting incidents. Learning from events was shared with staff and incidents were reviewed monthly at a quality assurance meeting.
- Arrangements in respect of in-cell storage for medicines had improved.
- Arrangements were in place for prisoners who did not want to manage their prescribed medicines.
- A 'Health in Justice Minor Ailments Protocol' was in place, which provided guidance on the management of homely remedies and a range of patient group directions (PGDs) were available to nursing staff. PGDs are written instructions to help clinical and non-clinical staff to supply or administer medicines to patients.
- We found electronic prescribing had improved the arrangements for repeat prescriptions.
- The primary mental health and secondary mental health nursing teams had integrated and were now operating as one team from the 2 March 2017.
- There had been an increase in the number of general nurses employed at the service along with the employment of a paramedic which meant that nurses were able to provide more contact time for patients with physical health needs. There were plans to develop a range of clinics for patients with long term conditions, for example, diabetes.
- Emergency resuscitation equipment was strategically placed around the prison. Equipment was organised, appropriate and in date.

Are services effective?

We did not inspect the effective domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 24 August 2016.

Summary of findings

- The majority of prisoners now received a comprehensive health assessment within 72 hours of their reception into the prison.
- As from the 20 March 2017 a weekly multi-disciplinary meeting now took place where all patients known to the mental health team were discussed. However there was no evidence that patients had been involved or consulted as part of this process.
- Daily referral meetings were also held to discuss all new referrals made in respect of prisoners' physical healthcare needs.
- Nurses, healthcare assistants and pharmacy technicians still did not receive regular supervision. Records showed that sporadic supervision sessions had taken place for some staff up to December 2016 with many sessions cancelled due to annual leave, sickness and a lack of nursing staff to deliver the day to day service.

Are services caring?

We did not inspect the caring domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 24 August 2016.

- There were no care plans in respect of patients with primary mental health care needs. Care plans were in place for patients known to the secondary mental health team and were of a good quality.
- Care planning for patients with long term conditions had begun but remained under developed.
- All patients located on the inpatient unit had a care plan and these too were of a good quality, however these care plans lacked patient involvement, there was a complete absence of patient consultation with regard to their care and treatment.
- Patients were not consulted about their treatment and changes to their prescribed medicines that led to a number of complaints by prisoners.

Are services responsive to people's needs?

We did not inspect the responsive domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 24 August 2016.

- Group and individual therapies were still not provided to patients with primary mental health needs, for example, anxiety management. The service remained undeveloped.

Summary of findings

- The inpatient unit was staffed by a registered mental health nurse throughout the day with health care assistants assigned to individual patients who required constant observation.
- Decisions to close an ACCT, for prisoners with a history of mental health problems were only made with the involvement of a clinician. Assessment, Care in Custody, and Teamwork, (ACCT) reviews are a prison care planning system used to identify and care for prisoners at risk of suicide or self-harm.
- Prisoners could now self-refer to mental health services and nurses responded in a timely manner. A new mental health pathway had been put in place from the 27 March 2017 and was not fully embedded at the time of our follow up inspection on the 4 and 5 April 2017. It was too early to assess the effectiveness of this system.
- A psychiatrist service was provided but there was no psychology service. This meant that overall patients still did not receive sufficient mental health services of an equivalent range as comparable with the community.
- A new complaints management process had been in operation since the 1 April 2017. At the time of our inspection all complaints, including historical complaints had been responded to. Since the 1 April 2017 there had been no complaints and therefore we were unable to assess the ongoing effectiveness of this new system.

Are services well-led?

We did not inspect the well led domain in full at this inspection.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- The provider must consult with patients ensuring that each patient receives appropriate person-centred care and treatment based on an assessment of their needs and preferences. The provider must work in partnership with the patient, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves.
- The provider must ensure that nurses, healthcare assistants and pharmacy technicians receive regular supervision to enable them to carry out the duties and responsibilities they were employed to perform.

HMP YOI Chelmsford Prison

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC health and justice inspector, accompanied by a Her Majesty's Inspectorate of Prisons healthcare inspector.

Background to HMP YOI Chelmsford Prison

HMP & YOI Chelmsford is a category B local and Young Offender Institution (YOI) and was built from 1830 onwards and became a young prisoners and local prison from 1987. Accommodating 745 young and adult offenders.

Care UK (H4H) Limited provide all health care services at the prison including, primary health care, mental health, a 12 bedded health care unit, GP services and dental services. The location, HMP Chelmsford registered to provide the regulated activities of, diagnostic and screening procedures and treatment of disease, disorder or injury.

CQC inspected healthcare services at the prison in partnership with Her Majesty's Inspectorate of Prisons from 11 to 14 April 2016. We found the provider, Care UK (H4H) was in breach of the regulations and we issued three Requirement Notices. We asked the provider to make improvements and we followed up on their progress during a focused inspection on 4 and 5 April 2017.

see link to report https://www.justiceinspectorates.gov.uk/hmiprisons/wp.../Chelmsford-Web-2016.pd

During this focused inspection, we found the provider had made improvements in some areas and had failed to make significant improvement in other areas. We have issued a requirement notice for Regulation 9 Person centred care and Regulation 18 Staffing. The provider remains in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the provider had met Regulation 12 Safe care and treatment.

Care UK (H4H) Limited is commissioned to provide health care services at the prison until 27 May 2017.

Why we carried out this inspection

This inspection was an announced focused inspection carried out on 4 & 5 April 2017. The purpose of the inspection was to confirm that the service provider, Care UK (H4H) Limited had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous joint inspection with Her Majesty's Inspectorate of Prisons between 11 & 14 April 2016 and in the Requirement Notice that we issued on the 24 August 2016. This report covers our findings in relation to those requirements.

Our key findings were as follows:

- There had been an increase in reported incidents due to better understanding and staff awareness of how to report incidents. Learning from events was shared with staff and incidents were reviewed monthly at a quality assurance meeting.
- Patients were not consulted about their treatment and changes to their prescribed medicines and this had led to a number of complaints by prisoners.
- Multi-disciplinary meetings now took place where all patients in treatment or known to the service were discussed. However there was no evidence that patients had been involved or consulted as part of this process and care planning remained under developed.

Detailed findings

- Group and individual therapies were still not provided to patients with primary mental health needs and the service remained undeveloped.
- A new mental health pathway had been put in place from the 27 March 2017 and was not fully embedded at the time of our follow up inspection on the 4 and 5 April 2017.
- Nurses, healthcare assistants and pharmacy technicians still did not receive regular supervision.
- There had been an increase in the number of general nurses employed at the service along with the employment of a paramedic which meant that nurses were able to provide more patient contact time.
- A new complaints management process had been in operation since the 1 April 2017

How we carried out this inspection

The inspection was led by a CQC health and justice inspector who was accompanied by a HMI Prisons health care inspector. Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. During the inspection we spoke with a range of healthcare staff, patients, a commissioner from NHS England and the prison's Governor.

To get to the heart of patients' experiences of care and treatment, we asked the following questions:

- Is it safe?
- Is it effective?
- Is it caring
- Is it responsive to people's needs?

Are services safe?

Our findings

Safe track record and learning

- At our previous joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in April 2016 we found incident reporting records showed that some risks to service safety and quality were not reported, which meant they may not have been addressed. This included the cancellation of urgent hospital appointments and staffing shortages. During our follow up inspection on 4 and 5 April 2017 we found there was an established system for reporting and recording incidents and since our last inspection there had been an increase in reported incidents. Staff we spoke with were familiar with reporting incidents and we were told that there was now an open culture across the service around reporting events. We saw learning from events was shared with staff and incidents were reviewed monthly at a quality assurance meeting. We reviewed safety records, incident reports and minutes of meetings where significant events were discussed. We saw reports in respect of significant incidents which included an analysis of the significant event.

Overview of safety systems and process

- At our previous joint inspection with HMIP in April 2016 we found that approximately 85% of patients received their medicines in possession. In-possession medication means that where possible, prisoners are given autonomy and responsibility for the storage and administration of their medication, dependent on individual risk assessments. A number of prisoners had concerns about the absence of secure in-cell storage in which to store their medicines. During this inspection we found that the arrangements in respect of in-cell storage had improved. We looked at a number of cells and observed that in-cell storage for medicine had been installed. Though some storage facilities had since been removed and others required keys.
- We previously found that prisoners who expressed a wish not to have their medicines in possession had to wait for a re-assessment before risks were identified and addressed. We found these arrangements had improved when we undertook a follow up inspection on 4 & 5 April 2017. An in-possession risk assessment was completed for all prisoners on reception to the prison, which was reviewed and updated every three to six months thereafter. Arrangements were in place for prisoners who did not want to hold in-possession medicines, which enabled them to return medicines to pharmacy technicians or treatment areas and then a nurse or GP would see the prisoner to review their treatment and options regarding medicines arrangements.
- At our previous joint inspection with HMIP in April 2016 we found that arrangements for nurses to supply medicines to patients to treat minor ailments in the absence of medical oversight were unsafe and contrary to professional guidance. There were no patient group directions or homely medicines policy in place to support safe practice. These arrangements had improved when we undertook a follow up inspection on 4 and 5 April 2017. We found that Care UK (H4H) had developed and put in place a 'Health in Justice Minor Ailments Protocol', which nursing staff worked to. We observed a large range of patient group directions (PGDs) available and deployed across healthcare. PGDs are written instructions to help clinical and non-clinical staff to supply or administer medicines to patients.
- At our previous joint inspection with HMIP in April 2016 we found systems to safely manage repeat prescribing were unreliable, causing delays in patients receiving their prescribed medicines and interruptions in treatment, posing a risk to their health and welfare. We found some improvement in these arrangements during our follow up inspection on 4 and 5 April 2017. We found that electronic prescribing had improved tracking and re-ordering of repeat prescriptions. Additionally patients could request repeat medicines by submitting a request slip. None of the patients we spoke with complained of delays in getting repeat medications, though we were made aware of a number of historical complaints about medicines issues including repeat prescriptions.
- Weekly pharmacist clinics were held and patients could request a review of their medicines. The purpose of the pharmacist review was to assist the patient in getting the most out of their medicines or address any other difficulties they may be experiencing, for example, inhaler technique.
- During the inspection of the 4 and 5 April 2017, we were made aware of a number of prisoners who had complained to health care about changes to their prescribed medicines without them having been consulted. Some complaints concerned Gabapentin and Pregabalin. We were told that some patients attended the weekly pharmacist clinic to discuss why

their medicines had been changed, although the pharmacist was not responsible for making the change. Care UK (H4H) had a prescribing protocol and a reception process for Pregabalin and Gabapentin, which included the prisoner being advised at reception of the potential for abuse and dependence of these medicines. The protocol around prescribing these medicines included seeking external confirmation from a community GP; after which the prisoner would be reviewed and in consultation with the prescriber, a GP and alternative treatments identified. Care UK (H4H) staff were not following the protocol and were not discussing openly with patients the rationale for making changes to their medicines. We found that because the patient had not been involved and consulted about their treatment this had led to a number of complaints by prisoners.

- At our previous joint inspection with HMIP in April 2016 we found the management of clinical stock items was poor and did not ensure the safety or integrity of clinical procedures. We found multiple examples of clinical consumables whose expiry dates had passed. We found improvement in these arrangements during our follow up inspection on 4 and 5 April 2017. We found storage arrangements for medications were good. Stock sampled in the pharmacy and on the wings was in date. In-possession and stock items were stored separately.

Monitoring risks to patients

- At our previous joint inspection with HMIP in April 2016 we found primary mental health nurses spent a lot of time undertaking work related to physical health, including medicines administration and emergency response. This had severely reduced their capacity to meet the high demand for mental health assessment and services. During our follow up inspection on 4 and 5 April 2017 we found the primary and secondary mental health nursing teams had integrated and had been operating as one team from the 2 March 2017. Mental health nurses' duties included administering medicines on A wing (segregation wing) and combining this with daily assessments of prisoners in segregation. Mental health nurses also administered medicines to patients on the inpatient unit.
- The mental health team provided assessment and support across the wings to prisoners with mental health issues and support to prisoners located in the segregation wing, those on constant observations on the wings or in the inpatient unit. However mental health nurses still undertook daily reception duties which impacted on the amount of time they had to provide mental health services.
- At our previous joint inspection in April 2016 we found registered general nurses were in short supply and therefore unable to develop and deliver services equivalent to the wider community, including care and treatment for patients with chronic medical conditions. At the time of our follow up inspection on the 4 and 5 April 2017 we found that three registered general nurses had been employed since September 2016, one registered general nurse was employed since February 2017 and a paramedic in March 2017, who responded to emergency calls releasing primary care nurses to undertake planned care. We were told that a further two registered general nurses had been recruited and were currently going through pre-employment checks. It was anticipated that the increase in general registered nurses employed to support primary health care services meant that clinics for patients with long term conditions would be started.
- At our previous joint inspection with HMIP in April 2016 we found that there were insufficient nurses deployed to the inpatient unit to meet patients' needs. During our follow up inspection on the 4 and 5 April 2017 we found that the inpatient unit was staffed by a registered mental health nurse throughout the day with health care assistants assigned to individual patients who required constant observation. Night time cover was provided by one nurse (either an RGN or an RMN) and one healthcare assistant locked in the inpatients area.
- The service was currently managing a number of vacancies and these were covered by regular bank and agency staff. Since our last joint inspection in April 2016 a new interim head of healthcare had been appointed and took up their post on the 6 February 2017. A new regional manager had also been appointed in November 2016 and took up responsibility for HMP Chelmsford in January 2017. A mental health pathway lead had been identified with a fixed term contract until 27 May 2017. As some of these appointments were recent we were unable to assess the ongoing effectiveness to them.
- At our previous joint inspection with HMIP in April 2016 we found clinical tasks were routinely delegated to healthcare assistants in the absence of appropriate preparation and assessment of competence, which

posed a risk that patients, may not receive appropriate care and treatment. During our follow up inspection on 4 and 5 April 2017 we found that non clinical staff were skilled, trained and competent to undertake the roles and responsibilities assigned.

Arrangements to deal with emergencies and major incidents

- At our previous joint inspection with HMIP in April 2016 we found routine checking of clinical equipment was inconsistent and did not ensure such equipment was suitable and safe for use; particularly in relation to emergency medical equipment. We found improvement in these arrangements during our follow up inspection on 4 and 5 April 2017. Emergency resuscitation equipment was strategically placed around the prison. We sampled all emergency resuscitation kits and found the equipment to be well organised, consistent and appropriate. All contents were in date. We saw evidence that confirmed that emergency equipment was checked daily by nurses and weekly by a senior health practitioner.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- At our previous joint inspection with HMIP in April 2016 we found that secondary health checks were not routinely completed posing a risk that some patients' health needs were not identified or addressed. We found improvement in these arrangements during our follow up inspection on 4 and 5 April 2017. A sample of records we reviewed confirmed that all prisoners with the exception of one, who declined to participate in the process, had received a comprehensive health assessment within 72 hours of their reception into the prison.
- At our previous joint inspection with HMIP in April 2016 we found mental health services were not sufficiently multi-disciplinary, leading to patients experiencing delays in assessment and review. We found some improvement in these arrangements during our follow up inspection on 4 and 5 April 2017. As from the 20 March 2017 a weekly multi-disciplinary meeting took place where all patients in treatment or known to the mental health team were discussed including patients located in the inpatient unit. However there was no evidence that patients had been involved or consulted as part of this process.
- Daily allocation meetings/referral meetings were now held and attended by primary health care nurses, substance misuse nurses and a senior mental health nurse to ensure that clinical information or any concerns were shared and patients healthcare needs were met by the most appropriate nurse.

Effective staffing

- At our previous joint inspection with HMIP in April 2016 we found nurses were not supported by supervision to ensure they were able to fulfil their clinical roles. At our follow up inspection in April 2017 we found there had been minimal improvement and nurses, healthcare assistants and pharmacy technicians still did not receive regular supervision. Records showed that sporadic supervision sessions had taken place for some staff up to December 2016 with many sessions cancelled due to annual leave, sickness and a lack of nursing staff to deliver the day to day service. The provider did not monitor supervision arrangements to ensure it was happening in line with their supervision policy which stated that staff should, '…meet formally on a one-to-one basis with their Line Manager to discuss their work at least every 3 months;' and 'All employees receive at least 6 supervisions per year'.
- During our April 2017 inspection we were told that group supervision was provided via the 'primary care team meeting'. We saw minutes of the last two meetings, in which it was recorded that nurses could use the meeting as an opportunity for 'group supervision'. We did not see any evidence of issues raised by nurses during these meetings.
- Nurses and healthcare assistants reported that they had good access to informal support. All staff we spoke with were positive about their work and demonstrated a willingness to move forward and work with the new provider to develop the service.

Are services caring?

Our findings

Care planning and involvement in decisions about care and treatment

- At our previous joint inspection with HMIP in April 2016 we found there was an absence of meaningful care planning which took account of patients' wishes. There were no plans in place for patients with chronic physical health conditions, primary mental health needs or complex needs. During our follow up inspection on 4 and 5 April 2017 we found insufficient progress had been made in this area, despite the high level of bank and agency staff used by the service.
- On the 4 and 5 April 2017 we found there were no care plans in respect of patients with primary mental health care needs and it was difficult to understand from looking at care records what interventions were taking place and the reason for the involvement of primary mental health staff.
- On the 4 and 5 April 2017 we found that care planning for patients with long term conditions had begun but remained under developed. The examples we saw were appropriate and provided a sufficient level of detail on how a person's care needs were being met.
- On the 4 and 5 April 2017 we found care plans were in place for patients known to the secondary mental health team and were of a good quality.
- On the 4 and 5 April 2017 we found all patients located on the inpatient unit had a care plan and these were of a good quality, however these care plans lacked any evidence of patient consultation with regard to their care and treatment.
- During the course of inspection on the 4 and 5 April 2017 we found that patients were not consulted or involved in decisions regarding changes to their medicines, though patients had access to pharmacist reviews where they could discuss how to get the best out of their medicines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- At our previous joint inspection with HMIP in April 2016 we found group or individual therapies were not provided to patients by the primary mental health team. Interventions were mainly brief welfare checks that were not always conducted confidentially. During our follow up inspection on 4 and 5 April 2017 we found no progress had been made in this area. Group and individual therapies were still not provided to patients with primary mental health needs, for example, anxiety management. The service was undeveloped and lacked any semblance of IAPT type approaches usually provided at primary level. IAPT refers to 'Improving access to psychological therapies' and is a national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder.
- At our previous joint inspection with HMIP In April 2016 we found patients admitted to the inpatient unit were not adequately supported to participate in therapeutic or social activities. There were insufficient nurses deployed to the unit, frequently leaving one healthcare assistant and one officer to provide all care and support. This impacted on staff's capacity to provide a sufficiently therapeutic regime. During our follow up inspection on 4 and 5 April 2017 we found insufficient progress had been made in respect of this area. The inpatient unit was staffed by a registered mental health nurse throughout the day with health care assistants assigned to individual patients on constant watch. Despite appropriate healthcare staffing on the inpatient unit, meaningful interactions with patients was limited and nurses had to converse with patients through locked cell doors while attempting to provide some diversional activities, for example jigsaws that could be put through the door hatches.
- During our follow up inspection on 4 and 5 April 2016 we were made aware of an incident when a nurse had to cancel a prisoner's mental health assessment because they could not be unlocked by prison staff. We were also made aware of occasions when prisoners were unable to attend GP appointment as they had not been unlocked by prison staff. We were made aware of other situations when healthcare staff had been available but were unable to access patients as they were reliant of prison officers bringing patients for appointments.
- During our follow up inspection on 4 and 5 April 2016 we found that mental health nurses contributed to and attended an initial ACCT review, (Assessment, Care in Custody, and Teamwork). ACCT reviews are a prison care planning system used to identify and care for prisoners at risk of suicide or self-harm. Nurses and senior management from Care UK (H4H) assured us that a nurse always attended the first ACCT review which was a mandatory expectation. Decisions to close an ACCT, for prisoners with a history of mental health problems were only made with the involvement of a clinician.
- At our previous joint inspection with HMIP in April 2016 we found that primary mental health assessments were not completed by nurses until patients had been seen by a GP or psychiatrist. During our follow up inspection we found that access to mental health services had improved, prisoners could self-refer and nurses responded promptly. Referrals were discussed daily at the allocation meeting.
- A new mental health pathway had been put in place from the 27 March 2017 and was not fully embedded at the time of our follow up inspection on the 4 and 5 April 2017 and so we could not assess the full effectiveness of this system. However, the pathway included a mental health nurse who carried a radio and provided rapid response for mental health emergencies, which was a good initiative in supporting mentally ill prisoners.
- At the time of our follow up inspection on the 4 and 5 April 2017 we found that whilst a psychiatrist service was provided there was no psychology service. This meant that overall patients still did not receive sufficient mental health services of an equivalent range as comparable with the community.

Listening and learning from concerns and complaints

- During the inspection we were made aware of a number of complaints by prisoners about the arrangements in respect of medicines management. The head of healthcare made us aware of a backlog of 51 complaints dating back to November 2016. We looked at a selection of these complaints. We saw that the majority concerned medicines issues, for example, concerns about a change of medicines and prisoners were no longer receiving the medicines that they had previously

Are services responsive to people's needs?

(for example, to feedback?)

been prescribed in the community, primarily analgesics such as Pregabalin and being without medicines because they had run out. Other complaints concerned prisoners' dissatisfaction at not being able to access GP and healthcare services due to not being unlocked and escorted to healthcare by prison officers. We saw that some responses to complaints did not always address all the issues that the complainant had raised. However the majority of responses were courteous, and when appropriate offered an apology. At the time of our inspection all complaints had been responded to.

- In direct response to the recent backlog of complaints the head of healthcare established a new complaints management process, which had been operational since the 1 April 2017.The process included recording response times and a named person allocated to investigate and respond to the complainant, including details of resolution and action plans to address the complaint. Complainants could meet with a member of healthcare staff for 'face to face resolution', or make a formal complaint. We were unable to test the success of the new complaints process as the time of our inspection.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

We did not inspect the well led domain in full at this inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider must consult with patients ensuring that each patient receives appropriate person-centre care and treatment based on an assessment of their needs and preferences. Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider must ensure that nurses, healthcare assistants and pharmacy technicians receive regular supervision to enable them to carry out the duties and responsibilities they were employed to perform. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.