Review of compliance

Wirral University Teaching Hospital NHS Foundation Trust Arrowe Park Hospital	
Region:	North West
Location address:	Wirral University Teaching Hospital NHS Foundation Trust Arrowe Park Hospital Arrowe Park Road Upton Wirral Merseyside CH49 5PE
Type of service:	Acute
Regulated activities provided:	Treatment of disease, disorder or injury Assessment or medical treatment of persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic or screening procedures Maternity and midwifery services Termination of pregnancies

Review of compliance

	Nursing care Family planning
Type of review:	Planned_Review
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Information for the reader

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Introduction to our review of compliance

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards that everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards. This is called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and we will constantly monitor whether they continue to do so. We formally review a service when we receive information that is of concern and, as a result, decide we need to check whether it is still meeting one or more of the essential standards. We also formally review services at least every two years to check whether they are meeting all of the essential standards in each of their locations. Our reviews include checking all the available information and intelligence we hold about a provider. We may seek more information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for more information from the provider, and carry out a site visit with direct observations of care.

When we make our judgements about whether services are meeting essential standards, we will decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions, compliance actions or take enforcement action:

Improvement actions	These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.
Compliance actions	These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards, but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.
Enforcement actions	These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

How this report is presented

On page 5 below, there is a summary that shows whether the essential standards about quality and safety that were checked during this review of compliance are being met. The section on each outcome is set out in this way:

Outcome	Judgement
XX: The outcome number and title	**Whether the service provider is compliant, or whether we have minor, moderate or major concerns about their compliance**

Following the summary, there is a detailed section on the outcomes for each of the essential standards that we looked at. The evidence that we used when making our judgements for each one is set out in the following way:

Outcome XX (number): Outcome title

Details of the outcome, taken from our *Guidance about compliance: Essential standards of quality and safety*.

What we found for the Outcome

Our judgement

Our judgement about whether the <service/provider> meets the outcome described in the *Guidance about compliance: Essential standards of quality and safety*, or whether there are minor, moderate, or major concerns in relation to compliance.

Our findings

A summary of the evidence and findings used to reach our judgement, related to regulated activities as appropriate.

At the end of the report you will find details of:

- Any improvement and/or compliance action(s) that the service provider should make to maintain or achieve compliance with the essential standards of quality and safety.
- Any formal enforcement action that we are taking against the service provider.

Summary of findings for the essential standards of quality and safety

The table below shows the judgement that we reached for each of the essential standard outcomes that we reviewed.

Outcome	Judgement
1: Respecting and involving people who use services	**Compliant**
2: Consent to care and treatment	**Minor concern**
4: Care and welfare of people who use services	**Moderate concern**
5: Meeting nutritional needs	**Minor concern**
6: Cooperating with other providers	**Compliant**
7: Safeguarding people who use services from abuse	**Minor concern**
8: Cleanliness and infection control	**Compliant**
9: Management of medicines	**Minor concern**
10: Safety and suitability of premises	**Compliant**
11: Safety, availability and suitability of equipment	**Compliant**

12: Requirements relating to workers	**Compliant**
13: Staffing	**Minor concern**
14: Supporting workers	**Minor concern**
16: Assessing and monitoring the quality of service provision	**Compliant**
17: Complaints	**Compliant**
21: Records	**Minor concern**

Summary of key findings:

- In January 2010, Wirral University Teaching Hospital NHS Foundation Trust applied to the Care Quality Commission to be registered as a health care provider under the Health and Social Care Act 2008. As part of the application process all trusts were asked to declare their compliance with the essential standards of quality and safety. The trust has three locations and declared fully compliant against all regulations for one location and declared non compliance against 11 regulations at the other two locations including this location Arrowe Park Hospital. The provider supplied robust action plans identifying the shortfalls, actions planned, actions undertaken, time scales for compliance and the systems for monitoring/maintaining compliance. Using the setting the bar guidance the overall judgement for the provider was a Moderate concern. As the trust had declared the non compliances and supplied robust action plans the trust was registered without compliance conditions but an improvement letter was sent and progress monitored.

- This planned review of compliance was undertaken as a result of the declared none compliances at registration by the trust and information received from three relatives/service users.

- In performing this review of compliance, we looked at information held by the Care Quality Commission from other sources, and information sent to us by the trust as evidence of the work it had undertaken in response to our improvement letter. We also visited three wards at Arrowe Park hospital on the 21st September2010 unannounced to observe care, treatment and support, talk with patients and their visitors about their current experience of the hospital, and speak with the staff at this location. This visit was undertaken to gather further assurance of compliance as a result of information received from service users/relatives.

- Overall we found that the quality and safety of the care, treatment and support received by the patients at Wirral University Teaching Hospital NHS Foundation Trust, Arrowe Park Hospital were being provided to a satisfactory level. However as a result of the visit to Arrowe Park Hospital we have some moderate concerns regarding the documentation, risk assessments and records of care provided on one of the wards visited at this location. These were not always completed fully or in a timely manner to demonstrate that all appropriate care had been given (see what we found for Outcomes 4, 5 and 21).

- We found that the majority of the patients spoken with were positive about the meals served. We also observed that patients who required help taking meals and drinks were offered assistance in a dignified manner.

- We found that the trust has made progress against the agreed action plans submitted at the time of registration to achieve compliance and at the time of the review and visit a number have been completed. A number remain ongoing but are within the agreed time scales for completion.

- We found that the trust has arrangements in place for assessing and monitoring the safety and quality of their service from all relevant sources. The trust has recently reviewed its arrangements for monitoring service provision and compliance with the essential standards of quality and safety. (see what we found for Outcome 16)

What we found for each essential standard of quality and safety

The section below details the findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

Further detail about each of the outcomes described below can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

People who use services:

- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

Those acting on behalf of people who use services:

- Understand the care, treatment and support choices available to the people who use services.
- Can represent the views of the person using the service by expressing these on their behalf, and are involved appropriately in making decisions about their care, treatment and support.

This is because providers who comply with the regulations will:

- Recognise the diversity, values and human rights of people who use services.
- Uphold and maintain the privacy, dignity and independence of people who use services.
- Put people who use services at the centre of their care, treatment and support by enabling them to make decisions.
- Provide information that supports people who use services, or others acting on their behalf, to make decisions about their care, treatment and support.
- Support people who use services, or others acting on their behalf, to understand the care, treatment and support provided.
- Enable people who use services to care for themselves where this is possible.
- Encourage and enable people who use services to be involved in how the service is run.
- Encourage and enable people who use services to be an active part of their community in appropriate settings.

What we found for Outcome 1

Our judgement

The provider is compliant with Outcome 1: Respecting and involving people who use services

Our findings

At the time of registration the trust declared this outcome as non compliant and submitted an action plan that detailed the actions required to achieve compliance and the time scales by which compliance will be achieved.

The trust had identified a gap in the recognition of the national privacy and dignity agenda and the organisational impact this has on services. The action plan identified that the trust would raise the profile of the Respecting Dignity Group within the existing governance structure at the Hospital Management Board. The Terms of Reference of the group have been updated and a new Chair has been appointed, this was completed within the agreed time scale stated in the action plan.

The trust declared non-compliance as it had failed to update the Disability Equality Scheme to reflect progress made by the Action on Disability Steering Group (the scheme expired in December 2009). The revised scheme was completed and approved in February by the board, within the agreed timescale stated in the action plan.

The trust declared non-compliance as it felt it had a a lack of robust assurance relating to the use of the existing Equality Impact Assessment (EIA) tool in policy development and the business planning process. The trust was requested to integrate the EIA into the policy development and planning process within the timescale (28/2/10) stated in the action plan. The Equality Impact Assessments are incorporated into the policy development process and are now reported to the trust's Patient Experience Lead, who also has an oversight role for equality and diversity. The incorporating of Equality Impact Assessments into the business planning process has been progressed and a revised business plan template has been developed and is being presented to the appropriate Trust committee for approval.

As part of this review the trust was asked to submit a list of the evidence they use to monitor compliance against this outcome and the trust review of this evidence.

We also looked at the information we held the Care Quality Commission Quality Risk Assessment. This included information from Local Intelligence Networks (LINKs) the National Patient Safety Agency (NPSA), Patient Environment Action Team obtained during visits undertaken by them in February. The Quality Risk Assessment found the trust compared either better or much better than expected when compared to other trusts in relation to Patient Environment Action Team visits.

We spoke to a number of patients on the site visit and one patient and their relative told us that some staff could appear abrupt or uncaring at times. A number of patients did say at times they felt they were not always fully informed regarding their planned care The majority of patients told us they felt that staff were very busy but treated them with respect. We observed staff attending to patient needs and addressing patients in a in a respectful

manner. We discussed these comments with the management team at the end of the visit.

The trust has also undertaken a dignity and privacy questionnaire and the results of this questionnaire have been reviewed and recommendations forwarded to the patient experience leads. The results from this questionnaire have been used to form part of the divisional patient experience action plans. The trust uses information received from Matron monthly audits, the Patient Advisory Liaison team and complaints to monitor, identify and rectify issues relating to possible abuse.

Outcome 2:
Consent to care and treatment

People who use services:

- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

This is because providers who comply with the regulations will:

- Have systems in place to gain and review consent from people who use services, and act on them.

What we found for Outcome 2

Our judgement

Minor concern with Outcome 2: Consent to care and treatment

Our findings

As part of the review the trust was asked to submit a list of the evidence they use to monitor compliance against this outcome and the trust review of this evidence.

At the time of registration the trust declared this outcome as non compliant and submitted an action plan that detailed the actions required to achieve compliance and the time scales by which compliance will be achieved. The trust identified that the consent register was not up to date and a 09/10 consent audit had not been undertaken. The trust has stated it would be compliant by 31/03/10. The trust supplied a report as requested on 4 June 2010 and this report stated that the action plan was partially completed. A full audit of consent was undertaken in February and March 2010 and an action plan has been developed in response to the findings.

The updating of the Consent Register is overdue. The trust has extended access to this database to the Trust Medical Education Department to input data directly. This should result in the register being more up-to-date and accurate. The trust expects the register will have been updated later this year.

Therefore we still have a concern as the update of the consent register is ongoing. We will continue to monitor progress against the action plan and follow up as required.

The patient records we viewed demonstrated that consent to procedures was obtained and had been documented.

Outcome 4:
Care and welfare of people who use services

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

This is because providers who comply with the regulations will:

- Reduce the risk of people receiving unsafe or inappropriate care treatment and support by:
    - assessing the needs of people who use services
    - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met
    - taking account of published research and guidance
    - making reasonable adjustments to reflect people's needs, values and diversity
    - having arrangements for dealing with foreseeable emergencies.

What we found for Outcome 4

Our judgement

Moderate concern with Outcome 4: Care and welfare of people who use services

Our findings

At the time of registration the trust declared this outcome as non compliant and submitted an action plan that detailed the actions required to achieve compliance and the time scales by which compliance will be achieved. The issues that required addressing were a review of the trust major incident plan, failing to meet the national target in waiting times experienced by patients presenting at the A&E department and the lack of counselling available to women undergoing termination of pregnancy (including children and people with learning disabilities).The trust supplied a report as requested on 4 June 2010 by the Care Quality Commission following registration which detailed the progress in the completion of the agreed action plans.

The major incident plan has been amended and was re-assessed by the Associate Director of Resilience for Merseyside on behalf of the SHA in March. It has been publicised across the Trust via the intranet and is being disseminated to partner organisations such as the local PCT.

The trust identified the need to improve efficiency in the A&E department and also to improve the flow/patient journey through the hospital. The time scale agreed was 31/03/10. An action plan was developed covering the following areas: admission avoidance; process improvement; medical staffing levels and skill mix; leadership and culture; and physical bed capacity. The plan has been implemented and targets required by Monitor and NHS Wirral have been met.

The agreed timescale at registration for the review of counselling support is 31/12/10 to ensure that appropriate counselling support is accessible and delivered by appropriately trained staff for women undergoing termination in pregnancy. The trust has systems in place to ensure counselling support is provided and a Rapid Process Improvement Workshop was scheduled to be held late June to review the whole service and the provision of counselling is an integral part of this exercise. The agreed time scale for completion of this part of the action plan is 31/12/10

During the visit to Arrowe Park Hospital a random selection of patient records where reviewed on the three wards visited. It was noted on one ward pressure area risk assessments (Waterlow Scores) and nutritional risk assessments (MUST) had either not been undertaken or had not been reviewed within the trusts time scale for review. As a result the compliance inspectors requested the trust to provide the Waterlow scores and MUST scores for all patients present on the three wards. The compliance inspectors reviewed this information and found two wards had undertaken their Waterlow scores and MUST assessments and completed reviews. The ward where the original concern was identified had not reviewed the Waterlow scores or undertaken MUST assessments for a large number of patients. We were also concerned that a number of their patients were elderly and some had pressure sores, although we saw from the documentation that

treatment had been commenced in relation to the pressure sores.

We asked ward staff about patient risk assessments and staff were aware of the need to undertake and review such assessments. On the ward where the concern was found staff explained that some times they were missed due to pressure of work.

The issue was raised immediately with the trust management on the day of the visit. As a result the Waterlow and MUST assessments were immediately undertaken. The trust management also assured us they would investigate why this had occurred and had not been identified by the trust as part of their own on going monitoring. The trust has updated us on the actions the trust has taken following our visit to investigate and address the issues identified to ensure risk assessments are completed and reviewed in a timely manner.

Therefore we have a concern that some patients may not have all of their care needs identified, recorded or monitored. We will continue to monitor this and follow up as required.
We will also monitor and follow up the action plan submitted at registration by the trust regarding the provision/review of counselling services.

Outcome 5:
Meeting nutritional needs

People who use services:

- Are supported to have adequate nutrition and hydration.

This is because providers who comply with the regulations will:

- Reduce the risk of poor nutrition and dehydration by encouraging and supporting people to receive adequate nutrition and hydration.
- Provide choices of food and drink for people to meet their diverse needs making sure the food and drink they provide is nutritionally balanced and supports their health.

What we found for Outcome 5

Our judgement

Minor concern with Outcome 5: Meeting nutritional needs

Our findings

At the time of registration the trust declared this outcome as non compliant and submitted an action plan that detailed the actions required to achieve compliance and the time scales by which compliance will be achieved. The trust supplied a report as requested on 4 June 2010 by the Care Quality Commission following registration.

The trust is currently replacing the existing nutritional screening tool with the Malnutrition Universal Screening Tool (MUST) following a rolling programme. The agreed action plan timescale for completion of the roll out programme and audit was of 31/10/10

MUST was launched across the Trust for adult inpatients on 17/5/10, using a secure web-based system on the intranet, and the trust has stopped using the previous screening tool. Key Performance Indicators have been developed to monitor the use of MUST and will be reported monthly, with statistics provided for each ward. The guidelines on completion of MUST have been derived from the NICE guidelines on Nutrition Support for Adults.

During the visit to Arrowe Park Hospital a random selection of patient records were reviewed on the three wards visited. It was noted on one ward nutritional risk assessments (MUST) had either not been undertaken or had not been reviewed within the trusts time scale for review. As a result we requested the trust to provide the MUST scores for all patients present on the three wards we visited. We reviewed this information on site and found two of the wards had undertaken MUST assessments and completed reviews but the ward where the original concern was identified had not reviewed or undertaken MUST assessments for a large number of patients. We were also concerned that a number of these patients were elderly.

We asked ward staff about patient risk assessments and staff were aware of the need to undertake and review such assessments but some staff explained that some times they were missed due to pressure of work.

The issue was raised immediately with the trust management on the day of the visit. As a result the MUST assessments were immediately undertaken. The trust management also assured us they would investigate why this had occurred and had not been identified by the trust as an issue on this ward. The trust has updated us on the actions it has taken following our visit to investigate and address the issues identified to ensure risk assessments are completed and reviewed in a timely manner.

Therefore we have a concern that some patients may not have all of their nutritional needs identified, recorded or monitored. We will continue to monitor this issue and follow up as required.

During the visit we observed the serving of meals on two wards and found that assistance was given to patients in an appropriate manner. All three wards operate a protected meal time policy and ward staff told us that most of the time this is observed but some times

ward rounds do occur at these times. Staff told us they are able to order special diets and were aware of the red tray system for identifying patients who require assistance. Staff were aware of the MUST screening tool but on one ward care assistants did tell us they would like more training on the use of this tool.

We spoke to patients and most raised no concerns over meals provided and felt that if they needed assistance they could ask for help and had seen patients receiving help with meals during their stay.

The trust also undertakes its own monitoring of the red tray system and protected meal time policy and we reviewed the results of the Assisted Meal Times Audit undertaken by the trust. Where issues are identified the trust produces an action plan and monitors the action plan to ensure improvement takes place.

We will monitor the progress in the implementation of the new nutritional assessment tool by the trust as identified at registration and follow up as required

Outcome 6:
Cooperating with other providers

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

T**his is because providers who comply with the regulations will:**

- Cooperate with others involved in the care, treatment and support of a person who uses services when the provider responsibility is shared or transferred to one or more services, individuals, teams or agencies.
- Share information in a confidential manner with all relevant services, individuals, teams or agencies to enable the care, treatment and support needs of people who uses services to be met.
- Work with other services, individuals, teams or agencies to respond to emergency situations.
- Support people who use services to access other health and social care services they need.

What we found for Outcome 6

Our judgement

The provider is compliant with Outcome 6: Cooperating with other providers

Our findings

When we visited Arrowe Park Hospital we reviewed the arrangements in place for working with other providers involved in the care, treatment and support of a person who uses services which is shared or transferred to one or more services, individuals, teams or agencies.

The trust has a discharge policy and transfer policy that have been recently audited. The discharge policy includes the completion of a discharge action plan and continuing health needs checklist. A named nurse or midwife is responsible for the co-ordination of all the individual patient care needs including discharge planning.

The Primary Care Team (PCT) has an Integrated Community Discharge Team which assesses patients who may need intermediate care services based at the trust. The trust multi-disciplinary team including physiotherapists and occupational therapists undertake assessments prior to discharge. The trust has a Patient Flow Team that provides support and advice about discharge assessment.

We reviewed patient records and identified the use of the discharge action plan and referral to other providers as part of the planning. We saw in one record how assessments had been undertaken and recorded by the occupational therapist, social worker and physiotherapist. A multi-disciplinary meeting (Best Interests Meeting) had been held and was documented in the plan. The plan also included communication with relatives/carers.

One of the Ward Managers explained how discharges are planned and the role of the Integrated Community Discharge Team and how referrals are made to other providers.

A copy of the discharge action plan is given to the patient on discharge and a copy retained in the patient's notes. If a patient is discharged with intermediate care or to care homes a transfer checklist is also completed.

Outcome 7:
Safeguarding people who use services from abuse

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

This is because providers who comply with the regulations will:

- Take action to identify and prevent abuse from happening in a service.
- Respond appropriately when it is suspected that abuse has occurred or is at risk of occurring.
- Ensure that Government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice.
- Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.
- Only use de-escalation or restraint in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services.
- Understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns.
- Protect others from the negative effect of any behaviour by people who use services.
- Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.

What we found for Outcome 7

Our judgement

The provider is compliant with Outcome 7: Safeguarding people who use services from abuse

Our findings

As part of the review the trust was asked to submit a list of the evidence they use to monitor compliance against this outcome and the trust review of this evidence. As part of the registration application the trust declared non-compliance in relation to this outcome as the database recording completion of staff safeguarding training at Level 1 was not fully up to date. The trust action plan detailed the actions required to achieve compliance and the agreed time scale by which compliance will be achieved was 31/03/10. The trust supplied an update report on 4 June 2010 as requested by the Care Quality Commission which stated every member of staff has received mandatory training, but line managers were failing to return confirmation of completion. The Safeguarding Team circulated a reminder to all Managers reminding them to return confirmation of completion of staff training and have been inputting the data into their database. Statistics for compliance with mandatory training are now satisfactory.

We spoke to a number of patients on the site visit and only one patient and their relative felt that staff could at times be sharp and uncaring. The majority of patients felt that staff were very busy but treated them with respect. The compliance inspectors observed that staff attended to and addressed patients in a respectful manner. Patients were seen to be dressed in appropriate nightwear and their modesty and dignity maintained.

The trust has undertaken its own audit of the use of appropriate clothing for patients.

In addition the trust has also undertaken a dignity and privacy questionnaire and the results of this questionnaire has been reviewed and recommendations forwarded to the trust patient experience leads to form part of the divisional patient experience action plans. The trust uses information received from Matron monthly audits, the Patient Advisory Liaison team and complaints to identify and rectify issues relating to possible abuse.

Outcome 8:
Cleanliness and infection control

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found for Outcome 8

Our judgement

The provider is compliant with Outcome 8: Cleanliness and infection control

Our findings

As part of the registration application the Trust declared non-compliance in relation to this outcome as there was no overarching decontamination policy, although there are local decontamination guidelines available for all services in the Infection Control Manual and specific policies. A decontamination policy was required in line with the agreed deadline (30/6/10).

The trust supplied a report on the action plan progress on 4 June which stated that

a policy has been drafted and was currently out to internal consultation in line with the Trust's Policy on the Development and Management of Trust-wide Policies and Procedures. The policy was to be approved by the Hospital Infection Control Committee and the Hospital Management Board. It was planned that the policy would have been ratified, and come into force, by the end of June 2010 thus meeting the deadline.

At the time of review and visit the ratification of the policy had been completed and the action plan completed.

As part of the visit we observed the level of cleanliness in the ward and public areas and did not identify any issues over cleanliness. All areas seen appeared clean and tidy on the visit. Clinical waste appeared to be stored appropriately and we did not observe any build up of waste or used linen awaiting collection. The trust undertakes regular audits relating to infection control and cleanliness and any issues are escalated and dealt with.

Patients that spoke to us did not raise any concerns over the standard of cleanliness of the wards.

Outcome 9:
Management of medicines

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

T**his is because providers who comply with the regulations will:**

- Handle medicines safely, securely and appropriately.
- Ensure that medicines are prescribed and given by people safely.
- Follow published guidance about how to use medicines safely.

What we found for Outcome 9

Our judgement

Minor concern with Outcome 9: Management of medicines

Our findings

The trust declared non-compliance in relation to this outcome as only pharmacy staff have in place approved and standardised competence assessments to undertake medicines handling duties. The current electronic system for the production of discharge prescriptions does not indicate if a pharmacist review has taken place. The trust also identified concerns regarding compliance with national storage requirements of medicines on some wards. There are also a number of policies and procedures which require updating in order to allow the Trust to register with the Royal Pharmaceutical Society (RPS) and to obtain a Wholesale Dealers' Licence to carry out its Service Level Agreement for pharmacy purposes.

A competence-based assessment for all new staff handling medicines is under development and is expected to be complete by 1/7/10 in accordance with the originally-agreed action plan. The Clinical Director of Medicines Management and the Director of Information are to scope possible solutions which would allow discharge prescriptions to indicate that a pharmacist review has taken place. This should be complete by 15/2/11 in accordance with the originally-agreed action plan.

A Trust-wide audit of storage of medicines was undertaken in February 2010. An action plan will be developed by 30/6/10 and the process will be re-audited to assess improvements by 28/3/11.

The review of Standard Operating Procedures and Policies to ensure compliance with the RPS's requirements is not yet due for implementation – it is expected to be complete by 30/6/10 in accordance with the originally-agreed action plan. The review of procedures and policies against the MHRA's requirements is due for completion by 31/8/10, in accordance with the originally-agreed action plan.

We will continue to monitor the progress in the above actions as identified by the trust at registration and follow up as required to ensure they are completed within the agreed time scales.

The trust has introduced the use of red tabards to enable nursing staff to be easily identified by other staff and undertake the administration of medicines without out interruption. On the day of the visit staff were seen to wear these tabards during medication administration. We reviewed patient medication records and saw that all medications administrations were recorded as given or if not given this was recorded. The trust uses a computerised system and the recordings are made on printed off hard copies by hand and also on the computer record system. We noticed that if a medication is omitted the reason is not recorded on the hard copy but was recorded on the computerised record. One of the ward managers explained to us how medications should be ordered and how administration is recorded.

During our visit we did not observe any medications being left at patient bedsides or stored inappropriately. The trust has also undertaken an audit of medications left at bed sides which was made available to the inspectors at the site visit.

Outcome 10:
Safety and suitability of premises

People who use services:

- Are in safe, accessible surroundings that promote their wellbeing.

This is because providers who comply with the regulations will:

- Make sure that people who use services, staff and others know they are protected against the risks of unsafe or unsuitable premises by:
    - the design and layout of the premises being suitable for carrying out the regulated activity
    - appropriate measures being in place to ensure the security of the premises
    - the premises and any grounds being adequately maintained
    - compliance with any legal requirements relating to the premises
- Take account of any relevant design, technical and operational standards and manage all risks in relation to the premises.

What we found for Outcome 10

Our judgement

The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

In performing this review of compliance, we looked at information held by the Care Quality Commission from other sources and we did not identify any areas of concern in relation to this outcome. The Quality Risk Assessment informed the inspectors that the trust has achieved the NHS Litigation Authority (NHS LA) Risk Management Standards for Acute Trusts– Level 2 and National Patient Safety Agency (NPSA), Patient Environment Action Team (PEAT) scores where found to be good or excellent. Information from the trust demonstrates that the trust is working towards Level 3 accreditation with NHS LA and as part of this process the trust has reviewed a number of risk management policies.

During our visit to the three wards and trust public areas the facilities seen appeared to be in a good state of repair. Clinical waste and used linen was segregated and stored correctly whilst awaiting collection in the areas we visited. The nurse call system was working in all patient areas we visited. One patient did not have a nurse call set, this was raised with the ward manager and a replacement set provided.

We were also shown ward leadership audit summaries. These audits are used to check that areas requiring repair have been reported, Health & Safety risk assessments are recorded and they have been reviewed within the last 12 months. They also show that quarterly Health & Safety inspections and an Annual Ward Health & Safety Audit which is part of the trust risk assessment had been completed. The audit also checks that monthly fire checks are documented, fire exits are clear and information is available on the ward regarding dealing with major incidents.

Outcome 11:
Safety, availability and suitability of equipment

People who use services:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

This is because providers who comply with the regulations will:

- Make sure that equipment:
    - is suitable for its purpose
    - is available
    - is properly maintained
    - is used correctly and safely in line with manufacturers' instructions
    - promotes independence
    - is comfortable.
- Follow published guidance about how to use medical devices safely.

What we found for Outcome 11

Our judgement

Minor concern with Outcome 11: Safety, availability and suitability of equipment

Our findings

The Trust declared non-compliance with this outcome as it does not have a performance management system in place to monitor the effectiveness of training. The trust felt there is also insufficient evidence to give assurance that training is effectively monitored and evaluated. The trust action plan identified that a performance management system would be introduced within the timescale of 30/9/10. At the time of the site visit 21/09/10 the Trust has procured a new electronic inventory database. This will include a module recording what training has been provided and to whom and will facilitate better performance management of medical devices training than the current paper-based system. The Electronic BioMedical Engineering (EBME) department are currently populating the new database and it is envisaged that it will be operational by the end of September 2010.

Competency assessments are in place for the fifteen most commonly used items of equipment in the hospital. These assessments are either performed in the Clinical Skills Lab or on the wards. A regular report is to be generated from Safeguard (incident reporting and management software) which will list incidents relating to medical equipment and thus highlight areas where there may be a lack of familiarity with how to use certain items. The Trust considers that it is on target to meet the originally-agreed deadline in the action plan.

We will continue to monitor the action plan submitted by the trust at registration to ensure it is completed within the agreed time scale.

Staff that spoke with us and confirmed that they are able to access appropriate equipment for patient use. During the visit we were able to observe the use of pressure relieving mattress that had been supplied following risk assessment. These and other equipment seen visually appeared to be suitable for purpose.

Outcome 12:
Requirements relating to workers

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

This is because providers who comply with the regulations will:

- Have effective recruitment and selection procedures in place.
- Carry out relevant checks when they employ staff.
- Ensure that staff are registered with the relevant professional regulator or professional body where necessary and are allowed to work by that body.
- Refer staff who are thought to be no longer fit to work in health and adult social care, and meet the requirement for referral, to the appropriate bodies.

What we found for Outcome 12

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

At the time of the visit we had not been made aware of any concerns over the requirements relating to workers from the information held by us.

The trust was contacted and asked to provide additional information to demonstrate trust compliance with this outcome. The trust provided information on the policies and procedures followed for the recruitment of staff and pre-employment checks undertaken. The trust had completed a quarterly review of compliance against this standard prior to our request and supplied the inspector with the results of this review. The information supplied included the systems/records used to monitor compliance As part of the trusts review they also identified additional information which would be used to improve the evidence of compliance and assist further in the trusts monitoring of this outcome. The trust uses quarterly reports which are supplied to the Service Improvement Programme Board showing compliance with pre-employment checks. The trust also uses a CRB Compliance Tracker. This tracker includes details of staff and their CRB status, professional registration and right to work status.

During the visit we saw summaries of Ward Leadership Audits. These audits check that new staff have commenced/completed their documented local induction check list and have a Preceptor allocated to them. These audits also check that staff have had an individual review/appraisal and a personal development plan. If issues are identified from these audits action plans are produced, implemented and reviewed within an identified time scale.

The trust has shown that is has reviewed compliance against this standard and has systems in place to monitor compliance.

Outcome 13:
Staffing

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

This is because providers who comply with the regulations will:

- Make sure that there are sufficient staff with the right knowledge, experience, qualifications and skills to support people.

What we found for Outcome 13

Our judgement

Minor concern with Outcome 13: Staffing

Our findings

At the time of the visit there appeared to be adequate numbers of staff on the wards with an appropriate skill mix. We spoke to patients who told us at times they felt that staff were very busy and sometimes there did not seem to be enough staff on duty. Staff that spoke with the inspectors felt there were staff shortages at times. Staff also spoke about the newly introduced change in their shift patterns which in some instances they felt did not benefit patient care. The trust has systems in place to monitor staffing levels and were shortages are identified systems are in place to increase staffing levels or utilise other staff to meet shortages due to unexpected sickness.

Ward managers that spoke with the inspectors explained how they monitor staffing levels and raise any concerns over staffing levels or skill mix.

At the time of the visit we had not been made aware of any concerns over staffing levels or skill mix from the information held by us.

We discussed the change in shift patterns at the end of the visit and will monitor this issue as part of our routine engagement.

Outcome 14:
Supporting workers

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

This is because providers who comply with the regulations will:

- Ensure that staff are properly supported to provide care and treatment to people who use services.
- Ensure that staff are properly trained, supervised and appraised.
- Enable staff to acquire further skills and qualifications that are relevant to the work they undertake.

What we found for Outcome 14

Our judgement

Minor concern with Outcome 14: Supporting workers

Our findings

As part of the registration application the Trust declared non-compliance as not all staff receive an individual annual appraisal interview / review and stated in the action plan compliance by 31/3/11.

The trust supplied CQC with a report on the progress against the agreed time scale which stated - The Trust has revised the individual documentation for annual reviews and is launching the revised documentation. A revised corporate policy governing the process has been agreed with staff side representatives through the Partnership Development Group. The Human Resources and Organisational Development department is working with departments which have a below-average level of compliance with the individual review process to embed the process locally. Compliance with the individual review process is a key performance indicator which is reported quarterly to the Trust's Clinical Governance Programme Board. In the most recent quarterly report 46.7% were compliant.

During the visit we saw summaries of Ward Leadership Audits. These audits check that new staff have commenced/completed their documented local induction check list and have a Preceptor allocated to them. These audits also check that staff have had an individual review/appraisal and a personal development plan. If issues are identified from these audits action plans are produced, implemented and reviewed within an identified time scale.

We will continue to monitor the action plan submitted by the trust at registration to ensure it is completed within the agreed time scale.

Outcome 16:
Assessing and monitoring the quality of service provision

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

This is because providers who comply with the regulations will:

- Monitor the quality of service that people receive.
- Identify, monitor and manage risks to people who use, work in or visit the service.
- Get professional advice about how to run the service safely, where they do not have the knowledge themselves.
- Take account of:
    - comments and complaints
    - investigations into poor practice
    - records held by the service
    - advice from and reports by the Care Quality Commission.
- Improve the service by learning from adverse events, incidents, errors and near misses that happen, the outcome from comments and complaints, and the advice of other expert bodies where this information shows the service is not fully compliant.
- Have arrangements that say who can make decisions that affect the health, welfare and safety of people who use the service.

What we found for Outcome 16

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

The trust identified at registration that there were inconstancies in mechanisms for developing action plans for monitoring improvements to patient /staff experience at divisional level. The trust submitted and action plan to achieve compliance by 31/03/10

The trust supplied a report 4 June as requested that stated the action plan had been implemented within the agreed time scale.

The trust has made progress on improving divisional action planning and monitoring systems. The principal means of monitoring action plans in divisions is the Divisional Management Boards, which bring together senior clinicians and managers. The example given was the Medical Division, which has its own Clinical Governance Programme Board, mirroring a corporate-level committee of the same name, and each of the directorates within the division has its own clinical governance meetings, either fortnightly or monthly. The Surgical Division has directorate-level clinical governance meetings which include discussion and monitoring of action plans arising from patient experience surveys, and from national and local audits.

Patient Experience Leads have also been designated within each of the clinical divisions.

Patient Experience has now been included as a standing item in the divisional quarterly reviews and the most recent reviews included discussion of patient experience issues.

The Trust's performance management arrangements include quarterly performance reviews for each division. Starting with the most recent quarterly performance reviews, there is a standing item in the review programme relating to external reviews, audits and accreditations. These are addressed on an exception basis.

The Quality and Safety Department developed the Performance Management Tool, in the form of an Access Database, which was used to review the documentation submitted for each regulation as part of the CQC registration process in January 2010. The tool is also be used to monitor progress against action plans arising from such reviews, and allows trust leads and the Quality and Safety Department a single point of access for the management of the compliance evidence and the risk rating of individual regulations.

Operational leads are required to check evidence prior to the end of each quarter to confirm that it remains up-to-date and valid, and to attach updated documentation to the database using a hyperlink if necessary. They are required to confirm that compliance applies to each of the Trust's registered activities and each of its sites.

At the end of each quarter, the Quality and Safety Department will use the tool to review the evidence for a sample of four regulations. The initial quarterly review in March and April

focused on those standards for which non-compliance was declared in January and for which corrective action is due by April.

The initial findings of the quarterly reviews are discussed and confirmed with the relevant operational leads, and notified to the applicable Executive Lead. An action plan will then be produced to rectify any non-compliance. The action plan will be recorded on the Access database referred to above. Quality and Safety will follow up to check that the agreed actions have actually been implemented, as part of their subsequent quarterly review.

The findings and action plans from each quarterly review are reported to the following meeting of the Clinical Governance Programme Board which has executive level membership .The Medical Director's report to the Audit Committee will also summarise any issues from the reviews. Should moderate or major concerns be identified, the matter will be escalated to the Hospital Management Board. The HMB would also be notified in the event that any leads were repeatedly failing to provide evidence or respond promptly to information requests from reviewers. On an annual basis, Executive Leads will be required to undertake their own reviews of the evidence for those regulations allocated to them, and sign off to confirm whether they consider the regulation compliant.

As part of the review the trust was asked to submit a list of the evidence they use to monitor compliance against this outcome and the trust review of this evidence

Outcome 17:
Complaints

People who use services:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

This is because providers who comply with the regulations will:

- Have systems in place to deal with comments and complaints, including providing people who use services with information about that system.
- Support people who use services or others acting on their behalf to make comments and complaints.
- Consider fully, respond appropriately and resolve, where possible, any comments and complaints.

What we found for Outcome 17

Our judgement

The provider is compliant with Outcome 17: Complaints

Our findings

As part of the review the trust was asked to submit a list of the evidence they use to monitor compliance against this outcome and the trust review of this evidence.

The trust has a complaints system in place which is followed when concerns/complaints are raised. The Patient Advisory Liaison team provide support for patients/relatives who wish to raise concerns. Information is available to patients and relatives explaining how complaints can be raised. Once a complaint has been received it is investigated outcomes reached and a response sent to the complainant. All complaints are recorded and a monthly report summarising the complaints received are sent to all directorates. If required following the investigation of the complaint an action plan is produced. This has identified time scales and staff responsible for the implementation of the action plan and also review of the action plan to ensure it has been implemented fully and improvements made. The Divisional Management Boards ensure are responsible for ensuring all actions are implemented.

The trust was asked to provide a copy of the annual complaints audit as part of the review. This report provided an overview of both formal complaints and concerns raised with the Patient Advisory Liaison Service (PALS) during 2009/10. From this information themes and issues are identified, which when addressed and where appropriate, can support the Trust to improve services from the patients' experience and point of view.

As a result of the Care Quality Commission inpatient survey in May 2008 four patient kiosks were introduced with the purpose of providing further review of patient satisfaction and a Trust wide action plan has been developed to address the issues raised in the Inpatient Survey and concerns identified through the information gained through the Kiosks.

The patients we spoke to appeared aware of how to raise concerns and complaints and we saw information and posters through out the trust on the day of the visit providing information to patients, relatives and carers. The wards have patient hospital information booklets which contain information and these books are checked as part of the ongoing Nursing & Midwifery audits to ensure up to date information is available.

During the review the Care Quality Commission were made aware by a relative and patient of complaints they had raised with the trust. Although we do not investigate complaints this information and information provided by the trust resulted in the decision to undertake an unannounced site visit to the trust to look at the issues raised to gain assurance in relation to outcomes 4 &5.

Outcome 21:
Records

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

This is because providers who comply with the regulations will:

- Keep accurate personalised care, treatment and support records secure and confidential for each person who uses the service.
- Keep those records for the correct amount of time.
- Keep any other records the Care Quality Commission asks them to in relation to the management of the regulated activity.
- Store records in a secure, accessible way that allows them to be located quickly.
- Securely destroy records taking into account any relevant retention schedules.

What we found for Outcome 21

Our judgement

Minor concern with Outcome 21: Records

Our findings

The trust declared non-compliance in relation to this outcome as health records are not routinely culled eight years after treatment is completed. In addition there was no agreement within the organisation to destroy any health records (apart from those of patients who have not attended) since the introduction of Patient Care Information System in 1992 and deceased patient paper records. The trust produced an action plan to cull all records in line with the Data Protection Act by 31/12/10. At the time of the visit a detailed costed project plan had been devised by the Director of Information and the Information Governance Manager, and is to be presented to the Hospital Management Board.

We will continue to monitor the action plan submitted by the trust at registration to ensure it is completed within the agreed time scale.

During the visit to Arrowe Park Hospital a random selection of patient records were reviewed on the three wards visited. It was noted on one ward pressure area risk assessments (Waterlow Scores) and nutritional risk assessments (MUST) had either not been undertaken or had not been reviewed within the trusts time scale for review. As a result the compliance assessors requested the trust to provide the Waterlow scores and MUST scores for all patients present on the three wards. The compliance inspectors reviewed this information and found two wards had undertaken there Waterlow scores and MUST assessments and completed reviews but the ward where the original concern was identified had not reviewed the Waterlow scores or undertaken MUST assessments for a large number of patients. The compliance inspectors were also concerned that a number of the patients were elderly and a number had pressure sores, although treatment had been commenced and documented in relation to the pressure sores.

Therefore we have a concern that some patients may not have all of their care needs identified, recorded or monitored. We will continue to monitor this progress and follow up as required

Other than the above concern the records appeared to have been completed fully and all entries signed and dated. Computerised records are password protected and all staff with access to computerised patient records system have their own individual passwords.

The trust has recently undertaken a review of the hard copy nursing documentation and following this review has revised the documentation which is to be introduced shortly.

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
	See compliance actions below	
	Why we have concerns	**The outcome for people that should be achieved**

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The report should be sent within 7 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Termination of pregnancy.	**Regulation 9**	**Outcome 4.** **Care & welfare of people who use services**
	How the regulation is not being met As part of the application for registration the trust declared non compliance in relation to this regulation in response to the lack of counselling support for women undergoing termination of pregnancy (inc children and people with learning disabilities) The trust must ensure appropriate counselling support is accessible and delivered by appropriately trained staff for women undergoing termination in pregnancy including children and people with disabilities within the agreed time scale.	**The outcome for people that should be achieved** Patients are able to access appropriate counselling support from appropriately trained staff at Arrowe Park Hospital.
Treatment of disease, disorder or injury. Surgical Procedures	**Regulation 9**	**Outcome 4.** **Care & welfare of people who use services**
	How the regulation is not being met During our visit to Arrowe Park hospital one ward had not completed or reviewed patient risk assessments for nutrition and pressure areas. On this ward we could not find evidence to demonstrate that all required screening or assessment were performed and or reviewed for every patient.	**The outcome for people that should be achieved** The trust should ensure that all patients • Have all of their needs properly and fully assessed, including identifying risks and how these will be managed. • Have all documentation fully completed and reviewed as appropriate .

Treatment of disease, disorder or injury. Surgical Procedures Maternity & midwifery services	**Regulation 13**	**Outcome 9.** **Management of medicines**
	How the regulation is not being met As part of the registration application the trust declared non compliant and submitted and action plan to achieve full compliance. A number of identified actions have been implemented and a number are on going but remain within the time scales agreed at registration. The trust must implement the outstanding actions identified at registration with in the agreed time scales.	**The outcome for people that should be achieved** People who use services receive care, treatment and support that ensure the medicines given are appropriate and person-centred. The trust will ensure medicines management is undertaken in a safe manner reducing the risk to services users relating to the prescribing, administration, dispensing and storage of medicines. .
Treatment of disease, disorder or injury. Surgical Procedures Maternity & midwifery services	**Regulation 14**	**Outcome 5.** **Meeting nutritional needs.**
	How the regulation is not being met	**The outcome for people that should be achieved**
	As part of the application for registration the trust declared non compliance in relation to this regulation. The trust is currently replacing the existing nutritional screening tool with the MUST nutritional tool following a rolling programme. The trust must ensure the action plan to replace the existing nutritional tool with the MUST Nutritional Screening Tool is completed within the agreed time scale.	People using the services are supported to have adequate nutrition and hydration.
Treatment of disease, disorder or injury. Surgical Procedures	**Regulation 14**	**Outcome 5.** **Meeting nutritional needs**
	How the regulation is not being met	**The outcome for people that should be achieved**
	Nutritional screening had not been completed or reviewed for all patients on one ward we visited on 21 September 2010.	Systems must be in place to ensure patients using the service have their nutritional needs assessed/screened to ensure they

		are supported to have adequate nutrition and hydration.
Treatment of disease, disorder or injury. Surgical Procedures Diagnostic & screening procedures	**Regulation 16**	**Outcome 11.** **Safety, availability & suitability of equipment**
	How the regulation is not being met	**The outcome for people that should be achieved**
	As part of the application for registration the trust declared non compliance in relation to this regulation. The trust has partially implemented the agreed action plan. It is in the process of completing the outstanding action of populating the new electronic inventory database which will include a system for recording training.	People who use services are protected from harm from unsafe or unsuitable equipment and benefit from equipment that meets their needs that is operated and monitored by appropriately trained staff.
Treatment of disease, disorder or injury. Surgical Procedures Diagnostic & screening procedures	**Regulation 18**	**Outcome 2.** **Consent to care & treatment**
	How the regulation is not being met	**The outcome for people that should be achieved**
	As part of the registration application the trust declared non compliance and submitted an action plan to achieve compliance. The trust has completed a number of identified and agreed action points within the agreed time scales. The up date of the consent register is still outstanding.	This will ensure consent is taken by appropriately trained staff and that service users understand the options and choices available to them as part of the consent process
Treatment of disease, disorder or injury. Surgical Procedures Diagnostic & screening procedures Maternity & midwifery services Termination of pregnancies Nursing care Family planning	**Regulation 20**	**Outcome 21.** **Records**
	How the regulation is not being met	**The outcome for people that should be achieved**
	The Trust declared non-compliance in relation to this regulation as health records were not routinely culled eight years after treatment is completed. In addition there was no agreement within the organisation to destroy any health records (apart from those of patients who have not attended) since the introduction of Patient Care Information System in 1992 and deceased patient paper records. The trust is in the process	People who use the services can be confident that • Their personal records including medical records are accurate, fit for purpose, held securely and remain confident. • Other records, required to be kept to protect their safety and wellbeing are maintained and held

	of implementing a plan to cull all records in line with the Data Protection Act as identified in the application for registration within an agreed timescale of 31/12/10.	securely where required
Treatment of disease, disorder or injury. Surgical Procedures Diagnostic & screening procedures Transport services, triage & medical advice provided remotely Maternity & midwifery services Nursing care	**Regulation 23**	**Outcome 14.** **Supporting workers**
	How the regulation is not being met	**The outcome for people that should be achieved**
	The Trust declared non compliance in relation to this regulation as not all staff received an individual annual appraisal interview / review. The trust submitted an action plan with agreed time scales. A number of the action points have been implemented and the remaining points are being implemented and remain within the agreed time scale.	People who use services are safe and their health needs and welfare needs are met by competent staff

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

Enforcement action we are taking

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action being taken			
None being taken This action is being taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	**Timescale** (if applicable)
	How the regulation or section is not being met:	**The outcome for people that should be achieved:**	**To be met by:**