Mid and South Essex NHS Foundation Trust

Broomfield Hospital

Inspection report

Court Road
Broomfield
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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Broomfield Hospital

Requires Improvement ↑

Broomfield Hospital is operated by Mid and South Essex NHS Foundation Trust. The hospital provides local elective and emergency services to people living in and around the districts of Chelmsford, Maldon and Braintree. Medical wards provided by Broomfield Hospital include acute monitored and renal, elderly care, acute medical assessment, general medicine, stroke, respiratory, gastroenterology and hepatology, active home unit for patients medically fit for discharge and frailty assessment day unit.

Between January 2022 and December 2022 medical care had 32,663 admissions including 16,912 emergency admissions. The specialties with the highest number of admissions during the same period were general medicine (9,323), geriatric medicine (7,873) and medical oncology (5,783)

We carried out this short notice announced focused inspection of medical care on 12 July 2023.

The service was rated as inadequate following our previous inspection, in January and February 2023. Following our last inspection, we issued a warning notice under Section 29A of the Health and Social care Act 2008 because of concerns relating to poor governance, incomplete risk assessments, incomplete patient records, equipment not being maintained, patients' nutrition and hydration needs not being met and medication not being managed in line with the service's medicines policy.

As this inspection was a focused follow up inspection, we only looked at the key questions of safe, effective and well led. We carried out this inspection to determine whether improvements had been made against the requirements of the warning notice we issued at our previous inspection. Although the service had made improvements against the section 29A warning notice, this inspection did not look at the requirement notices that were issued at the previous inspection. As these requirement notices remain, this meant the ratings were limited to requires improvement.

Our rating of this service improved. We rated the service from inadequate to requires improvement. During this focused inspection, not all breaches identified at the last inspection were reassessed to include all potential improvements.

We found:

- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to obtain consent from patients.
- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Our findings

However:

- The service needed to continue to embed processes and evidence this improvement through continued audit.

Medical care (including older people's care)

Requires Improvement 

Our rating of this service improved. We rated it as requires improvement. See overall summary for details.

Is the service safe?

Requires Improvement 

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

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Patients could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. We reviewed the emergency trolleys on Tollesbury, Tiptree, Braxted and Writtle wards. Staff completed emergency trolley checks on a daily and weekly basis. There was evidence of staff rechecking, restocking, and retagging the emergency trolley following any emergency event on the ward. Equipment on emergency trolleys was in date and the trolleys were visibly clean and safety tagged. This was an improvement from our inspection in January 2023.

The service had enough suitable equipment to help them to safely care for patients. We reviewed 45 separate items of equipment across four wards Tollesbury, Tiptree, Braxted and Writtle wards. Equipment we reviewed included air flow mattresses, vital sign monitors, blood pressure monitors, patient weighing scales, hoists, fire extinguishers, suction, and automated external defibrillators (AED's). Staff ensured that equipment had been service stamped and the equipment was in date for service review. This was an improvement from our inspection in January 2023.

The service was engaged in a system wide change in patient mattresses and were replacing all standard mattresses with a hybrid mattress that could be attached to an air flow pump to create a pressure relieving mattress. Staff accessed the new systems directly from the services storage areas. The aim was to reduce the waiting times associated with ordering and delivering pressure relieving mattresses. This meant that patients could access pressure relieving equipment without significant delays, that hospital acquired pressure ulcers could be minimised and improve patient outcomes. This was an improvement from our inspection in January 2023.

The service had introduced guidance telling staff how to access and use ligature cutters in the event of a patient ligation. We visited Tollesbury, Tiptree, Braxted and Writtle wards and noted staff displayed guidance on how to access and use ligature cutters next to the emergency trolleys. All emergency trolleys carried ligature cutters in a designated area of the trolley in a tagged dated pouch. This was an improvement from our inspection in January 2023.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Medical care (including older people's care)

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 12 patient records and found that staff had completed the appropriate risk assessments in relation to providing safe care. This was an improvement from our inspection in January 2023.

Staff used a nationally approved tool to identify patients at risk of deterioration and escalated them appropriately. Staff used the national early warning score system (NEWS2) for adults. An early warning score is a guide used by staff to quickly determine the degree of illness of a patient based on their vital signs. Staff recorded patient NEWS on a handheld IT device, linked to a centralised patient monitoring system, which alerted staff if the patient's NEWS increased or decreased so they could escalate the patient for additional medical intervention where required. We reviewed 12 patient records and found that nursing and medical staff had completed the appropriate NEWS assessments and escalation to enable them to provide safe care.

The service had made a significant change to the written and electronic patient record systems which had reduced the amount or paper records staff completed for each patient. Staff completed and updated records for pressure ulcer prevention and management, nutrition, and hydration, falls and the use of bed rails. Our review of patient records showed that staff clearly recorded where bed rails were in use and linked the decision to use bed rails to patient capacity and safety. Following our inspection, the service provided audit data of staff compliance with record keeping and risk assessment completion between 20 June and 1 August 2023 for the wards we inspected. The data showed that staff achieved 100% compliance with completing bed rail risk assessments on Tollesbury, Tiptree and Braxted ward. Staff on Writtle ward achieved 90% compliance.

Data supplied by the service following our inspection showed there were 545 patient falls across the medicine wards at Broomfield hospital between January 2023 and June 2023. The highest number of falls was on the stroke ward, and the highest number of falls across the medicine wards occurred in May 2023, with 107 patient falls recorded. Staff we spoke with described patients entering the hospital with more complex needs related to age and frailty. Data supplied by the service following our inspection showed staff achieved 100% compliance in June 2023, with completion of patient falls risk assessment documentation on all but two wards. We reviewed the services joint falls and tissue viability action plan and noted the service had completed all of the actions. This was an improvement from our inspection in January 2023.

At our previous inspection in January 2023, the service had introduced a pressure ulcer management booklet for all staff to complete to improve the identification and management of pressure ulcers. The service set an 80% compliance rate for staff across all of the medicine wards. Data provided by the service following our inspection, showed that staff on all of the medicine wards had achieved above the 80% compliance. This was an improvement from our inspection in January 2023.

Staff used electronic systems alongside the written patient records to record some patient details, for example the patient's weight, or their venous thromboembolism (VTE) assessment. VTE is a condition that occurs when a blood clot forms in a vein and can include deep vein thrombosis (DVT) and pulmonary embolism (PE). Following our inspection, we asked the service to provide us with data on staff compliance with VTE risk assessment and reassessment. The service told us there was an issue with the data for June 2023 due to operational IT updates, therefore they provided data from April and May 2023. Data showed that in April 2023, 8 out of the 9 specialties reporting VTE risk assessment and reassessment compliance achieved above 80% compliance, with 7 achieving above 85%, and the majority of specialties achieving above 90%. Data from May 2023 showed 8 out of the 9 specialities achieved above 80% compliance, and the majority of specialties achieving above 90%.

Medical care (including older people's care)

Data supplied by the service following our inspection, showed that between January 2023 and June 2023, there were 174 hospital acquired patient pressure ulcers across the medicine wards. Staff we spoke with told us the service was focusing on pressure ulcer management. Staff had completed shadow shifts with the services tissue viability nurse and completed additional training on recognising and promoting pressure ulcer management. Staff described the REACT to red process they followed, including pre-empting patient pressure ulcers using a practice called “Protect the Sacrum.” This is where staff identified any reddening or pressure ulcer warning markers on the patient’s sacrum, and in liaison with the tissue viability nurse applied a surface dressing to protect this area of skin from breaking down and forming into a pressure ulcer. The service was engaged in a system wide change in patient mattresses to replace all standard mattresses with a hybrid mattress which could be attached to an air flow pump to create a pressure relieving mattress.

Staff shared key information to keep patients safe when handing over their care to others. The service had implemented a medical assurance document (MAD) on all medicine wards to replace its old staff handover sheets for recording and sharing key patient information. The MAD was date ordered to prevent information being lost and drew together key information for the shift including staffing allocation to ward areas. Leaders also recorded the allocation of mealtime coordinators to ensure protected mealtimes and that staff used a red tray system for patients who had additional eating and drinking needs.

Shift changes and handovers included all necessary key information to keep patients safe. The MAD book gave staff the opportunity to record key information to provide continuity of patient care and highlight any changes in need. Examples of leaders sharing information included changes in patient discharge plans, safeguarding concerns, any newly identified risks, feedback from relatives or learning from incidents and complaints to prevent future harm.

Staff used large wall mounted display screens placed at the nurse’s station on each ward to track patient ward moves, bed occupancy and bed allocation. This system linked to additional electronic patient record management systems and enabled staff to see dates patient risk assessments were completed, key dates for review and whether the patient had a mental capacity assessment or a deprivation of liberty safeguard in place, and any additional special staffing needs. Staff we spoke with said the system was very beneficial to them and gave them easy access and oversight of patients who may need additional support or need increased supervision to manage any risk.

Records

Staff did not always keep detailed records of patients’ care and treatment.

We reviewed 12 sets of records and found inconsistency in the way staff completed the records and, in some cases, how the patient records were organised within the patients record folders. For example, staff did not always record their name, their role or date and time clearly into the written patient record. We also found some patient information was not organised clearly in some patient record folders, whilst in other patient folders we found the records were well organised and easy to follow. The service was aware of the inconsistency and organisation issues and implemented a number of new and simplified written patient records to improve staff compliance with written record keeping. For example, on Braxted ward we found patient records to be comprehensive and well organised and staff had started to embed the new written patient record systems. Other wards were taking action to improve their written record keeping whilst implementing the new patient records and staff compliance was reviewed as part of the services governance processes.

Following our inspection, the service provided audit data of staff compliance with record keeping and risk assessment completion between 20 June and 1 August 2023. For example, staff on Tiptree, Braxted and Writtle wards achieved 100% compliance with completion of Waterlow documentation. Staff on Tollesbury, Tiptree, and Writtle achieved 100% compliance with completing patient food charts, staff on Braxted ward achieved 66.7% compliance. Staff on Tollesbury,

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Tiptree, Braxted and Writtle all achieved 100% compliance with completing the patient's fluid balance chart. Staff on Tiptree and Braxted ward achieved 100% compliance with the patient's MUST assessment being completed within 12 hours of admission. However, staff on Tollesbury achieved 90% compliance with this standard, and staff on Writtle ward achieved 80% compliance demonstrating inconsistency in record completion across the wards.

As part of the services improvement and governance processes the service was looking how the written and electronic records would work in the future and whether it would move to a single electronic patient record.

The service used both electronic and paper patient records, following our inspection in January 2023, the service had combined some of its written nursing and medical records into one folder to improve communication, ease of access and consistency in recording and monitoring patient care. Staff we spoke with were extremely positive about the new record systems and were keen to show us the new paperwork and how beneficial they had found this.

Electronic records were password protected and only authorised members of staff could access them. Paper records were stored in a lockable cabinet or in file holder outside the bays or on the patients' bed footboards.

Is the service effective?

Requires Improvement ↑

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

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Following our inspection in January 2023, the service had reintroduced protected mealtimes for all wards. This meant that mealtimes were protected from non-essential activities. We observed lunchtime on 2 wards and noted staff adhered to the protected mealtime process.

To support protected mealtimes, ward leaders identified mealtime coordinators at the beginning of each shift who were responsible for coordinating mealtime activities. These staff ensured that all patients had their needs recorded, including any specialist diets or drinking needs and assigned staff to patients who needed additional support. On Writtle ward we observed a member of the medical team asking a healthcare assistant (HCA) if they could see a patient. The HCA explained that it was protected mealtime and the member of the medical team left the ward and said they would come back later to see the patient once the protected mealtime was over.

During our inspection, we visited Tollesbury, Tiptree, Braxted and Writtle wards. Patients had fresh drinking water, hot drinks, cordial, or juices within reach. Patients who needed assistance with drinking had a red toped water jug within reach. The red top signalled to staff and volunteers that the patient needed additional support with fluids. Staff used a white board above the patient's bed to show if they were nil by mouth, or on specific fluid or food regimes.

Staff used a red tray system to identify patients who needed additional support with eating or were on a specialist diet, for example blended meals, or high or restricted calorie meals. Any patient who needed a red tray had this recorded in their patient record, and above their bed side, the mealtime coordinators also worked with the hostess on the ward to ensure the red tray system was used. Staff had access to a range of adaptive equipment, for example slip mats and breakers to help patients to eat and drink more independently.

Patients that were able to have snacks had biscuits, fruit, and various drinks within reach on their bed side cabinets or tables. Patients we spoke with told us staff routinely asked them if they needed additional food or drinks and that the food was usually nice, and they had options to choose from each day. We noted that staff and volunteers interacted positively with patients during mealtimes, and that the ward was quiet and well organised.

Hostess staff we spoke with were clear on their responsibilities in relation to supporting patients to ensure they had the right meals. They told us they would inform staff where patients had not completed their red tray meal, and alerted staff to any patient who they were concerned about or who had not eaten their meal or drunk fluids. They also knew if patients had any specific preferences, for example vegetarian, vegan or El-Halal products.

Staff completed patients' fluid and nutrition charts where needed. Following our inspection in January 2023, the service had introduced new separate fluid balance and food intake charts which were kept with the patient comfort rounding charts at the end of the patient's bed. The food intake chart was now on pink paper, to ensure it was identifiable from the white fluid intake cart. Staff we spoke with said that changing the colour and placing these records with the patients' comfort rounding tool meant it was much more accessible and easier to see and record patient information so they could escalate any patients of concern.

Patient records we reviewed showed that staff were routinely completing the food intake charts for patients and escalating any concerns to the ward leader for action. We raised concerns at our last inspection in January 2023, that staff were not completing patient fluid balance charts. We found staff were completing the fluid balance chart, but not always adding this up at the end of each shift. Leaders we spoke with said this was a cultural issue and the service had an action plan to continue to improve compliance.

The service was consistently updating its IT capabilities, including the patient record system. We found that patient weight was recorded both electronically and in the written documentation. Leaders we spoke with told us as they developed the systems, they would be auditing record completion and were aiming to move towards one centralised patient record in the future.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to the patient malnutrition universal screening tool (MUST). We reviewed 12 patient records and found that in all cases where a MUST was required staff had completed this accurately and it was up to date. Following our inspection, we asked the service to provide MUST audit data from the wards we visited during our inspection. The data showed that between 1 June and 27 July 2023 staff on Writtle and Braxted ward achieved 100% compliance with MUST completion and staff on Tiptree ward achieved 85.7% compliance. Audit data showing if the MUST had been reassessed a minimum of weekly or if there was a change in patient's clinical condition showed that staff on Braxted ward achieved 100% compliance with this standard. Staff on Tiptree achieved 71.4% compliance and staff on Terling ward achieved 58.3% compliance. The service had a nutrition and hydration quality improvement project and action plan in place to address any shortfalls in compliance.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff we spoke with told us that therapy teams, for example speech and language therapists, and occupational therapists would support them and were responsive to requests for support.

The service had made some improvements to ensure mealtimes were protected and patients were supported with their nutrition and hydration needs. The service will need to continue to embed protected mealtimes and monitor progress.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and treatment. Staff we spoke with knew the importance of recognising when a patient may lack the capacity to make a decision and the impact this may have on their care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We routinely observed staff seeking patient consent prior to any activity and ensuring as far as reasonably possible that patients understood what was happening and why.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed patient mental capacity act assessment and Deprivation of Liberty Safeguards (DoLS) held within the individual patient records. These demonstrated that staff had taken the patients best interests into account and involved family or relatives where appropriate as well as other health care professionals in the decision-making process.

Staff clearly recorded consent in the patients' records. Patient records we reviewed showed that where patients required a mental capacity assessment or DoLS staff had recorded this appropriately. Leaders had implemented a new system for managing DoLS referrals to improve the flow of information and ensure the MCA and DoLS were in date and had been reviewed to ensure they reflected the capacity assessment and any restrictions placed on patients.

Nursing and medical staff received and kept up to date with training in the MCA and DoLS. Following our previous inspection in January 2023, the service's safeguarding team had delivered bite size training on the MCA for nursing and medical staff. A total of 28 sessions had taken place across all 3 sites and 413 staff attended the sessions. On 15 June 2023, the service held a 4-hour long MCA and DoLS masterclass for staff and partner agencies and over 150 professionals attended the session. The service told us these bite size sessions were not mandatory and they were unable to provide details of compliance with the sessions.

In May 2023 the service made MCA and DoLS training mandatory, and this was added to the services statutory mandatory training list on the services electronic learning platform that went live in June 2023. This training consisted of 1.5 hours face-to-face session, and they were planning to hold 39 sessions between August 2023 and April 2024. Information shared by the service following or inspection showed nursing staff achieved 97% compliance with MCA training at level 1 and 95% compliance with level 2. Clinical staff achieved 81% compliance with MCA training at level 1 and 77% compliance with level 2.

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Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff we spoke with knew who to contact for advice and guidance on the MCA and DoLS process. Staff we spoke with had either completed the bite size MCA learning provided by the service or had requested to complete the course.

Managers monitored the use of DoLS and made sure staff knew how to complete them. The new system adopted for submitting and tracking DoLS meant that leaders could review all DoLS applications and ensure these reflected the mental capacity assessments. Managers discussed mental capacity assessments, DoLS requests or authorisations with the staff team to ensure that care plans encouraged the least restrictive options to promote the health and wellbeing of patients.

Staff could describe and knew how to access policy and get accurate advice on the MCA and DoLS. Staff we spoke with told us they could access policies and procedures on the services intranet. They could also seek advice from their manager, the services MCA lead, MCA ward champion or from the services local safeguarding lead who would visit the ward routinely.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The leadership team had implemented a new IT based system for monitoring the process of recording and submitting a DoLS application. During our inspection we reviewed patients with an MCA and DoLS in place and found staff used approved documentation, that MCA's and DoLS were up to date and reflected the patient's needs.

Patient records we reviewed demonstrated that staff had completed, where appropriate, do not attempt cardiopulmonary resuscitation (DNACPR) forms for patients. Following our inspection, we asked the service for its most recent DNACPR compliance audits for the wards we visited. Data showed that staff on Tollesbury ward achieved 100% compliance, staff on Braxted ward achieved 95.8% compliance and staff on Writtle ward achieved 90.3%.

The service had made improvements to ensure that mental capacity assessments and Deprivation of Liberty Safeguards were managed in line with legislation and guidance to ensure that required assessments were completed and appropriate actions were identified to protect patients from avoidable harm. The service will need to fully embed the process and progress monitored.

Is the service well-led?

Requires Improvement ↑

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

Governance

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

The service had structures, processes, and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The service had governance structures in place, staff described governance processes as ward to board. This enabled staff to share key information on risk and performance from ward level to the services board members and various safety, risk and performance groups for oversight and accountability. At our last inspection in

Medical care (including older people's care)

January 2023, we identified that the service was not compliant in a number of areas related to patient safety and risk, for example the completion of patient records and managing risks. At our most recent inspection, we found that there were ongoing issues with staff completion of records, however the leadership team were taking steps to address performance and improve compliance to mitigate risks.

Ward and departmental meetings fed into specialty team meetings, the divisional board, care group board and governance and then to the governance subgroups. The groups met monthly and reported to the board sub committees, quality governance committee and then the services board. Following our inspection, the service had implemented a service wide audit of divisional governance meetings to ensure that the services divisions were using the correct service meeting templates and adopting appropriate governance processes. This was an improvement from our inspection in January 2023. However, the service must continue to embed governance processes and evidence improvement through continued audit ensuring learning is shared across all core services.

We reviewed the services most recent governance meeting records from June 2023, which showed staff discussed key patient quality and safety issues and concerns to identify any emerging risks and review existing risks across the service. Areas covered included audit outcomes, learning from incidents, staff performance and recruitment, and emerging risks across the service. The service had an up-to-date risk register, with key actions required to mitigate risk, dates, and staff ownership. The service had updated the risk register with feedback from our last inspection, demonstrating the service had listened and responded to our inspection feedback in order to improve the quality and safety of the service to patients.

The service reviewed governance structures and processes. Leaders had increased the local governance and oversight processes in relation to auditing and monitoring risk and performance. For example, the implementation of the medical assurance document (MAD) on all medicine wards to record and share key information. We observed increased oversight and improved processes for managing patient risk in relation to capacity and consent, staff compliance with monitoring patient risk assessments and leaders routinely fed back to staff on performance and audit outcomes. This was an improvement from our inspection in January 2023.

Staff at all levels were clear about their roles and understood what they were accountable for. The service had updated the staff clinical governance handbook to provide clarity on the governance structures, systems, and process and this has been issued to senior leadership teams and governance staff and made available on the services intranet. The booklet included information on key governance systems and process, for example management of risk and issues and governance meetings and was a guide for staff in addition to the formal policies and procedures already in place. Leaders also shared feedback and learning from complaints and incidents to minimise risk.

Staff of all levels carried out appropriate daily, weekly, and monthly audits in line with the services audit schedule to monitor risk and performance. For example, staff compliance with completion of patient falls risk assessments, recording and monitoring patient nutrition and hydration and the early detection and management of pressure ulcers. Matrons undertook planned peer to peer audits, and sample audits of staff compliance with the audit schedule. Leaders gave feedback to staff on their compliance with carrying out daily checks and audits, and shared key information on patient safety to minimise ongoing risk of harm. We found that staff had completed checks on emergency equipment, ensured medicines were stored and refrigerated appropriately and general equipment within the ward areas was serviced in line with manufacturers guidance to promote patient safety and minimise risks. This was an improvement from our previous inspection in January 2023.

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Areas for improvement

Action the trust MUST take to improve:

- The service must continue to embed governance processes and evidence improvement through continued audit ensuring learning is shared across all core services. (Regulation 17 – (1-2 (a) (b) (c))

Action the trust should take to improve:

- The service should continue to embed protected mealtimes for all patients and promote the opportunity for them to eat and drink safely, ensure that staff meet patients' nutritional, and hydration needs, having regard to the patient's well-being (Regulation 9 – (1(h) (i))
- **The service should continue to ensure that mental capacity assessments and Deprivation of Liberty Safeguards are managed in line with legislation and guidance to ensure that required assessments are completed and appropriate actions are identified to protect patients from avoidable harm. (Regulation 11 – (1) (2) (3))**
- The service should continue to ensure that all staff complete patient records to ensure they are accurate, up to date and legible and that all risk assessments are completed to maintain patient safety. (Regulation 17 - (1 (c))
- The service should ensure that it continues to provide suitable premises to care for patients presenting with mental health conditions and ensure all equipment and the estate is maintained and serviced appropriately. (Regulation 15 - (b) (c) (d) (e))

Our inspection team

Our inspection Team

The team that inspected the service comprised a CQC lead inspector, and one specialist advisor. The inspection team was overseen by Hazel Roberts Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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