Essex Partnership University NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

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Date of inspection visit: 05 and 06 October 2022
Date of publication: 03/04/2023

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Inadequate 

Essex Partnership University NHS Foundation Trust provide community health, mental health and learning disability services for a population of approximately 1.3 million people across Essex, Bedfordshire, Suffolk and Luton. Essex Partnership University NHS Foundation Trust provides acute wards for adults of working age and psychiatric intensive care across fifteen wards on five sites. The acute wards are part of the mental health services delivered by Essex Partnership University NHS Foundation Trust. These wards provide assessment and treatment in an inpatient care setting for adults either admitted on an informal basis and/or patient detained under the Mental Health Act 1983.

The Care Quality Commission (CQC) have registered this service for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

Following the inspection visits on 5 and 6 October 2022, the CQC sent a Letter of Intent to the Trust. A Letter of Intent means CQC considered using potential urgent enforcement action. We asked the Trust to respond and submit an action plan as to how they would improve the quality and safety of care, by 11 October 2022. The Trust submitted their action plan within the required timeframe.

Following review of the action plan the CQC was not fully assured. On 31 October 2022 CQC issued a Warning Notice under Section 29 of the Health and Social Care Act, asking the Trust to make significant improvements by 18 November 2022 regarding:

- Patient observations
- Sufficient numbers of regular staff
- Patient consent
- Blanket restrictions
- Incident reporting
- Ligature cutters

See our website for more information about Section 29 Warning Notices:

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/enforcement-policy

What we found:

- Staff did not always follow Trust policies and procedures, despite systems being in place which provided them with training and induction.
- Staff did not always follow the Trusts' policies and procedures with regards to patient observations.
- Staff did not always follow the Trusts' policies and procedures with regards to recording and reporting of incidents.

Our findings

- There were very high levels of vacancies and sickness amongst nursing and support staff across both wards. This meant that there were many different temporary staff working on the wards that were not familiar with the patients.
- High use of bank and agency staff meant that not all staff knew the patient's individual needs, despite the trust systems to record patient risk and care plans.
- The Trust had not ensured that work was completed to address the inability of staff to observe patients from all areas (blind spots).
- The Trust had not ensured that all aspects of care and treatment of patients was provided with the consent of the relevant person.
- The Trust had a policy in place to manage restrictive practices which allowed staff to restrict access to certain areas within the ward based on risk. However, this meant that all patients on the ward were restricted from areas such as the gardens, bedrooms, bathrooms and toilets.
- The Trust did not ensure ligature cutters were consistently accessible for staff.

However

- Staff were kept up to date with mandatory training.
- Staff received regular supervision and appraisals.
- Staff felt well supported by their leaders.
- Staff assessed patients' physical health on admission and during their time on the ward.

Background to the inspection

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services. CQC were informed by Essex Partnership University NHS Foundation Trust of a scheduled broadcast on Channel 4 in October 2022.

We visited two of the Trust's fifteen acute and PICU wards, these were the two wards identified in the Channel 4 television programme.

We suspended this trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

How we carried out the inspection

Due to the focused nature of this inspection we looked at four key questions; safe, effective, caring, and well led. We did not inspect all key lines of enquiry across every key question. Because of its limited scope, we did not set out to rate at this inspection. However, during this inspection we identified breaches of regulations. This means the rating linked to the domain the breach sits under will normally be limited to 'inadequate'.

During the inspection we:

- visited 2 wards and observed how staff cared for patients;
- viewed extracts of CCTV and body camera footage;
- toured the clinical environments;

Our findings

- spoke with 9 patients who were using the service;
- interviewed 10 staff members and ward managers;
- spoke with 7 carers;
- reviewed 7 patient records;
- reviewed 11 prescription charts;
- reviewed 10 patient observation charts;
- reviewed policies and procedures, data and documents relevant to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with 9 patients who were using the service and 7 carers.

Patients told us:

- Staff were mostly nice, kind and helpful, especially the day-time staff.
- One to one therapeutic time with a named nurse didn't always happen.
- There was not always enough staff and at times there were lots of different staff working on the ward.
- Escorted leave was sometimes cancelled.
- They cannot easily access the bathrooms and gardens.
- Three patients told us night-time staff were sometimes less understanding, compassionate and helpful than day-time staff.
- Three patients told us that they had seen staff sleeping on duty.

Carers told us:

- Staff were caring, respectful and polite.
- They knew how to make a complaint or raise a concern should they need to.
- Most carers told us they felt informed and were kept up to date. However, one carer told us communication was poor and another told us it was mixed.
- Sometimes the wards were short-staffed.

Is the service safe?

Inadequate 

Our rating went down from requires improvement to inadequate. This is because we identified breaches of regulations. This means the rating linked to the domain the breach sits under will normally be limited to 'inadequate'.

Our findings

See our website for more information about rating principles: https://www.cqc.org.uk/guidance-providers/nhs-trusts/ratings-principles-nhs-trusts

Safe and clean care environments

Wards were clean, well equipped, well-furnished and fit for purpose.

Safety of the ward layout

Staff completed risk assessments of all wards areas and reduced any risks they identified. We saw both Galleywood and Willow wards had ligature risk assessments in place that identified ligature risks and blind spots. The latest ligature risk assessment for Galleywood ward was undertaken in July 2022. For Willow ward this was undertaken in September 2022.

Managers had completed plans for both wards to reduce potential risks identified in the ligature risk assessments. The manager for Galleywood ward had provided comment against each potential risk stating how that risk was being reduced. From this risk assessment several actions where identified of which, 3 were rated as high priority. The manager for Willow ward had identified 7 areas for action, none of which were high priority. Both managers had also completed an accompanying action plan, and we noted that these actions were complete.

Managers made sure that staff on the wards had easy access to ligature packs with information on environmental risks. This included a map of hotspot areas. Staff we spoke with knew about any potential ligature anchor points, where ligature cutters were located and felt confident in their abilities should they need to use these. Staff could describe mitigations taken to reduce risks to patients' safety.

During our inspection we noted that storage of ligature cutters differed on the two wards. On Willow ward all ligature cutters were stored in one bag. On Galleywood ward the different cutters were placed in individual bags in the nursing office. This was not in line with Trust policy. We were concerned that differing practice across the two wards could lead to staff being confused about the process for accessing these in an emergency.

On the day of the inspection, the manager of Willow ward told us that adjustments were being made to improve the storage of the ligature cutters. We saw maintenance work taking place during the inspection.

Staff could not always observe patients in all parts of the wards. Managers identified areas where staff could not observe patients and mitigated this by convex mirrors or staff observations. This was recorded this within the ligature risk assessments. However, we found one example where a blind spot in the lounge on Galleywood ward had been identified at the most recent ligature risk assessment of July 2022. The ward manager had requested convex mirrors to be installed. However, on the day of inspection this work had not been completed. The risk assessment showed that mitigation was in place and managers had made staff aware of the hotspots through the patient safety hotspot chart and ensured a member of staff sat in this room.

Staff had identified a potential blind spot in the garden at Galleywood ward. Staff had reduced the associated risk by keeping the garden door locked. This meant that patients could only access the garden under the supervision of staff.

We saw CCTV was used in communal areas and staff wore bodycams on both wards. The Trust had a surveillance system policy and a body worn camera protocol in place. The policy stated that bodycams should be worn during each shift and be activated when and where an incident is taking place. Staff confirmed they were encouraged to switch the body camera on to film any patient safety incidents.

Our findings

During inspection we were told that the wards had a contact-free patient monitoring and management system. We were told this system helped clinicians to plan care and intervene proactively by providing them with location, activity-based alerts, warnings and reports on risk factors. Staff told us that consent was obtained from patients on admission to the ward. Whilst we saw consent forms in admission packs, four patient records reviewed at Willow ward and three records reviewed at Galleywood ward did not show evidence of patient consent to the system on admission, and there was no evidence in the patient records that the system had been revisited with patients on the ward after admission. During the inspection, two patients on Galleywood ward told us they could not remember giving consent for its use. One patient on Galleywood ward told us they were not aware of the system in their bedroom.

The ward complied with guidance and there was no mixed sex accommodation, both wards were female only.

Staff had easy access to personal alarms and could call for extra staff to support in emergencies.

Patients on Willow ward had access to nurse call alarm systems in their bedrooms. However, there were no alarms in bedrooms for patients to access nurse call systems on Galleywood ward. This meant that staff relied on the contact-free patient monitoring and management systeme to alert them to patient concerns.

Maintenance, cleanliness and infection control

Willow ward was clean, bright, well maintained, well-furnished and fit for purpose. However, Galleywood ward was tired and in need of some redecoration. Managers had made attempts to brighten the environment with colourful murals in communal areas.

On Galleywood ward we observed an over-flowing bin in the lounge and one patient told us they had bugs in their bins.

Clinic room and equipment

Clinic rooms were clean, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough permanent nursing staff, who knew the patients well and keep people safe from avoidable harm.

Nursing staff

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

The service had very high vacancy rates. At the time of inspection, the vacancy rate for registered nurses was 81% (Willow ward) and 56% (Galleywood ward). The vacancy rate for Nursing Support Workers was 39% (Willow ward) and 43% (Galleywood ward).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

Our findings

We reviewed bank and agency usage from 15 August 2022 to 11 September 2022. The service had high rates of bank and agency staff. We found bank and agency staff were regularly used on both day and night shifts across both wards. We saw examples of shifts where managers had been able to book additional unregistered bank and agency staff to undertake engagement and supportive observations of patients who needed a high level of observation.

Managers attempted to limit the use of bank and agency staff by requesting and booking staff familiar with the service in advance. For example, Galleywood ward had block booked agency staff until end of January 2023. However, we reviewed the staff rosters and found during the period 15 August 2022 to 11 September 2022, 33 different registered staff worked on Willow ward. For the same time period we found 25 different registered staff worked on Galleywood ward.

During the period 15 August 2022 to 11 September 2022 169 different unregistered staff worked on Willow ward. For the same time period we found 81 different unregistered staff worked on Galleywood ward.

This meant there was a high number of different temporary staff working on the ward. Patients told us that not all staff on the wards were familiar with their individual needs.

The service had variable turnover rates. We reviewed the staff turnover rates from June 2022 to August 2022. Willow ward had the highest staff turnover rate in this time period and was 22.2% for July 2022. Galleywood ward had a 0% staff turnover rate in this time period.

Levels of sickness were high due to the low number of permanent staff and high staff vacancy rate. We reviewed sickness levels from June 2022 to August 2022. The monthly staff sickness rate in this time period ranged from 3% to 13% for Willow ward. The staff sickness rate in this time period for Galleywood ward ranged from 2% to 13%. The trust target for sickness rate was below 12%.

Patients told us they did not always have regular one to one sessions with their named nurse.

Patients told us sometimes they had their escorted leave cancelled and staff we spoke with confirmed this.

The service had enough staff to carry out any physical interventions. Staff told us they could access additional staff to support in emergencies through the rapid response procedure. Designated staff from neighbouring wards could assist to emergency call alarms. Staff told us that staff always responded to rapid response calls.

Mandatory training

Staff employed by the Trust had completed and kept up to date with their mandatory training. Training compliance rates ranged from 81% to 100%.

The mandatory training programme was comprehensive and met the needs of patients and staff. This meant the Trust provided a full suite of mandatory training courses suitable to this service.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Managers told us that a central team in the Trust had responsibility for ensuring that agency staff deployed on the ward had the appropriate training for the role. All agencies under the approved NHS agencies framework had full responsibility for ensuring agency workers received and were up to date with the NHS mandatory training standards. We reviewed training rates for agency staff for the period 1 April 2022 to 30 September 2022, 100% of agency staff working across both wards were up to date with the required training.

Our findings

Assessing and managing risk to patients and staff

Staff assessed and regularly reviewed patient risk. However, staff did not always manage risks to patients well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a or soon after and reviewed this regularly, including after any incident.

We reviewed 7 patient records. Staff had completed risk assessments for patients on admission or arrival. Staff regularly reviewed risk assessments at the weekly multi-disciplinary meetings and more frequently when required. However, we found two of the records on Galleywood ward where the risk assessment had not been updated following an incident. We saw these incidents had been recorded in the ward round notes.

Patients had their physical health assessed soon after admission and were regularly reviewed during their time on the ward.

Management of patient risk

Staff had not always conducted patient observation in line with trust policy. We reviewed 10 observation records and found all records were fully completed except for one that was completed incorrectly. For one patient on Willow ward, staff had recorded Level 2 (intermittent) observations every 15 minutes, instead of four times an hour at irregular intervals. This practice did not follow the Trust's own policy.

During inspection, one staff member was observed to be sitting in a chair outside a patient's bedroom on Galleywood ward, when the patient was on 'within eyesight' observations. The nurse was observed to be reading a care plan book. Following inspection, managers told us that the nurse was using the care plan book to engage with the patient.

We reviewed CCTV footage of one staff member briefly appearing to fall asleep whilst undertaking a patient's observations on Willow ward a few minutes before being replaced by another member of staff.

During our inspection we interviewed 9 patients, out of which, 3 patients told us that they had seen staff sleeping on duty. One patient told us they had heard a staff member snoring whilst undertaking their observations. Two patients told us that they had seen staff on their mobile phones. We reviewed body cam footage where another patient disclosed to staff they had seen a staff member sleeping and had recorded this on their mobile phone. We reviewed one piece of CCTV footage where we saw a member of staff using their mobile phone whilst in the nurses' office. However, managers told us the use of mobile phones in non-patient areas is within Trust policy.

We reviewed incident data for the period 1 May to 5 October 2022. During this time there were 2 reported incidents of staff sleeping whilst on observations for Willow ward.

We reviewed an incident on 19 September 2022 on Willow ward where a member of staff undertaking one to one (continuous) observations of a patient, had recorded that the patient had attempted to tie a ligature.

We reviewed incident data for the period 1 May to 5 October 2022 and found one incident where a detained patient was able to leave Galleywood ward whilst on level 3 (continuous) observations through a back door. We viewed CCTV footage of this incident where the patient reached the multi-storey car park within the hospital grounds.

Our findings

Use of restrictive interventions

Levels of restrictive interventions varied across the two wards. We viewed data from 1 May 2022 to 5 October 2022. During this time there had been 9 incidences of restraint on Galleywood ward, of which once incident resulted in staff administering rapid tranquillisation. On Willow ward, for the same time period, there had been 80 incidences of restraint of which, 8 had resulted in medication being used (10%). There had been no reported incidents of the use of prone restraint.

Staff we spoke with told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We viewed CCTV and bodycam footage for 3 restraint incidents. We found in 2 of the 3 incidences (both on Willow ward) that staff had attempted to use de-escalation techniques. However, staff attempts at de-escalation for both of these incidents had been unsuccessful and resulted in restraint.

We found that CCTV footage of the third restraint incident on Galleywood ward, had not matched the description of the incident within the incident report. The incident report described the patient as kicking the door of the nurses' office. We watched footage for an hour before the incident but whilst CCTV showed the patient as having been agitated, the patient was not observed to be physically aggressive. From the footage it was not clear the patient restraint was necessary.

We found evidence of restrictive practices on both wards. During inspection we saw on Galleywood ward that the garden was locked. Staff told us that patients needed to be supervised when outside. We also saw the ward toilets were locked (there were a total of 6 toilets of which 2 were currently out of order). One patient was observed asking to go to the toilet, however the staff member did not have keys and had to go and find another staff member with the keys. We found patient bathrooms and showers were also locked.

On Willow ward patients had to ask a staff member to go into their bedroom. The manager told us this was because patients were unwell, therefore they could lose their bedroom key fobs. We found the door to the garden was locked and staff on Willow ward told us patients were not able to go out into the courtyard unsupervised.

Safeguarding

Staff understood how to protect patients from abuse and who to inform if they had concerns. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Permanent staff were 100% compliant with both levels two and three safeguarding training for both adults and children. Agency staff were 100% compliant with levels one, two and three safeguarding training for both adults and children.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw posters on the safeguarding process on display in the ward.

We saw evidence that safeguarding incidents were reported, actioned and lessons learnt.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward managers were the leads for safeguarding and worked with the Trust safeguarding team who had responsibility for overseeing the safeguarding process.

Our findings

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All permanent and bank staff had a log in to access patient notes and electronic systems and records. There were guest log ins for agency staff.

Records were stored securely.

Medicines management

Staff completed medicines records accurately and kept them up to date. We reviewed 11 prescription charts across the two wards and found they were complete.

Staff stored medicines and prescribing documents safely.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff had not always recognised incidents or reported them appropriately. Managers investigated reported incidents and shared lessons learned with the whole team.

Staff we spoke with told us what incidents to report and how to report them. However, out of the 7 patient records reviewed, we found 3 examples (one incident on Galleywood ward and two incidents on Willow ward), where incidents recorded within the patient notes had not been reported on the Trust reporting system.

We reviewed incidents for both wards between 1 May 2022 and 5 October 2022. During this time Willow ward had reported 313 incidents. For the same time period Galleywood ward had reported 119 incidents. We saw evidence of the different categories of incidents staff reported and incidents were reported to the National Reporting and Learning System (NRLS).

Managers had investigated these incidents and took actions. Lessons learnt had been identified and staff told us these were shared at team meetings. Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they felt supported after incidents and that debriefs took place.

Between 1 May 2022 and 5 October 2022 one incident of a staff member sleeping whilst on patient observations been reported on Willow ward. Managers took immediate action however, no lessons learnt were recoded within the incident report.

The service had no never events on either of the two wards. Never events are serious incidents that are wholly preventable.

Is the service effective?

Inspected but not rated

Our findings

We suspended this Trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

Rating remains suspended.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were regularly reviewed.

We reviewed 7 patient care records and found staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Care plans were regularly reviewed, and we saw evidence of patient involvement. We saw examples of "My care, My recovery" plans.

We saw evidence that patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Records showed that staff developed a comprehensive care plan for each patient that reflected their mental and physical health needs.

Within the 7 records we viewed staff had regularly reviewed and updated care plans when patients' needs changed.

Skilled staff to deliver care

Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. We saw competency folders and staff checklists were in place on the wards to familiarise new staff in key areas such as patient hotspots, ligature cutters, safeguarding, medical emergencies and incident reporting.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. We reviewed training rates for agency staff for the period 1 April 2022 to 30 September 2022. During this period, 100% of agency staff working across both wards were up to date with the required training.

Managers supported staff through regular, constructive appraisals of their work. Managers had ensured that 100% of staff were up to date with their appraisal on both wards.

Managers supported non-medical staff through regular, constructive clinical supervision of their work 83% of eligible staff on Willow ward and 100% of eligible staff on Galleywood Ward. We were told the lower percentage on Willow ward was due to staff sickness absence.

Is the service caring?

Inspected but not rated

Our findings

We suspended this Trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

Rating remains suspended.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness.

Patients on Galleywood ward told us that staff treated them okay, but they were often busy and the ward was short of staff.

Patients on Willow ward told us that day-time staff treated them well. However, three patients told us night-time staff were sometimes less understanding, compassionate and helpful than day-time staff.

Carers told us that most staff were caring, polite and respectful and showed an interest in their friend or relative's wellbeing. However, one carer told us that night staff were not as communicative.

During our inspection we observed some positive patient and staff interaction. For example, on Willow ward, we saw the ward manger and staff speaking compassionately and calmly to a patient that was distressed.

However, during our inspection we observed staff in the garden at Galleywood ward talking amongst themselves, not engaging with patients.

We viewed a piece of CCTV footage on Galleywood ward of a distressed patient. There was minimal engagement made by staff.

Is the service well-led?

Inspected but not rated

We suspended this Trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

Rating remains suspended.

Leadership

Leaders were visible in the service and approachable for patients and staff.

Staff told us leaders were supportive and approachable. Staff knew who the local leaders were. Most staff knew who the most senior managers in the organisation were or where to find that information.

Culture

Staff felt respected, supported and valued. However, staff were stretched and there was low morale.

Our findings

Staff we spoke with said they felt leaders and their colleagues were supportive and felt respected and valued by their line managers.

However, some staff reported feeling stretched and there was low morale. They told us there were high levels of patients that were very unwell on the ward that was challenging. Staff raised concerns about the low levels of permanent staff and high use of temporary staff. This meant that there had been a high number of different staff working on the wards. Whilst staff reported good team working amongst permanent members of staff, some staff told us that continuity of care had been an issue on both wards.

The service had a whistleblowing policy in place. Most staff we spoke with were aware of this and were confident they would use this if required.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level.

The Trust did not have effective systems and process in place to assess, monitor and improve the quality and safety of the services or mitigate risks to patients such as not all staff were following trust policy and procedures. We saw examples of this for incident reporting and recording, patient observations and ligature storage policies.

The service had high vacancy and sickness rates. Managers were heavily reliant on the use of bank and agency staff to fill shifts.

The Trust did not have effective monitoring systems in place to ensure they are improving and learning. During a Mental Health Act Review visit of 12 and 13 April 2022 we found patients could not access the garden on Willow ward without restriction. The Trust told us they had taken action and that the door “will only be closed if there is an emergency or a potential risk that requires staff attention”. On the day of our inspection the ward environment was calm however, the garden door was still locked.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for the recording and reporting of incidents.
- The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for patient observations and engagement. The Trust must take immediate action to ensure that staff do not fall asleep when undertaking patient observations.
- The trust must take immediate steps to review and reduce all blanket restrictions on the wards, where it is safe to do so.
- The trust must ensure there are sufficient numbers of regular staff working on the wards who are familiar with individual service user needs.
- The trust must ensure that maintenance work is completed to address the inability of staff to observe patients from all areas (blind spots).
- The trust must ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed.
- The trust must ensure ligature cutters are stored in line with trust policy.
- The trust must ensure that all patients have access to nurse call alarms.

Action the service SHOULD take to improve:

- The Trust should consider how to manage and record any individual patient objections to the contact-free patient monitoring and management system.
- The trust should ensure that actions are taken to improve staff morale.

Our inspection team

The inspection team included two CQC inspectors and a specialist nurse advisor. The team visited two wards, Willow ward and Galleywood ward, on 5 and 6 October 2022 and completed off-site inspection activity between 5 October to 21 October 2022.

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 Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation