# Ellingham Hospital

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Ratings

| | |
|---|---|
| Overall rating for this location | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Requires improvement |

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Overall summary

The Care Quality Commission carried out a comprehensive inspection of Ellingham Hospital on 8 and 9 January 2019

We issued a warning notice against Regulation 18 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enforcement actions we told the provider to address are found at the end of the report.

During inspection we found that:

- We were concerned that the hospital continued to admit patients without assurance of being able to provide appropriate numbers of staff. Staff shortages, particularly for qualified staff, and high usage of bank and agency staff had an impact on both staff and patients. Staff regularly did not have time to take breaks, engage in activities, support new staff or fully complete paperwork. The provider did not provide sufficient staff to ensure patients accessed escorted leave in accordance with what had been agreed with them. Staff and patients told us that section 17 leave was often cancelled or delayed for patients requesting to leave the hospital. This was supported by section 17 paperwork.
- We were not assured that the enhanced observations were carried out safely. The provider policy for observations and engagement said that staff must not be continuously on 1:1 observations for more than two hours. Staff said that this was not always possible as there was often a high level of patients requiring observations. This included multiple staff observations where a patient required more than one staff with them at all times. On Redwood ward we saw that one support worker was tasked with supporting 14 patients on intermittent observations. We reviewed 13 observation records on Redwood ward. Of these 12 did not identify the individual patient risk. This meant that staff carrying out observations may not be aware of the reason for the observation level. However, the records were signed as complete.
- We were not satisfied that all serious incidents were being reported and reviewed by managers regularly. We found paper incident forms not uploaded on the electronic system in a timely manner on Cherry Oak Ward. We could not see rigorous identification and sharing of lessons learnt across all three wards.

# Summary of findings

## Contents

Requires improvement

# Ellingham Hospital

**Services we looked at:**

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

**Child and adolescent mental health wards**

# Summary of this inspection

## Background to Ellingham Hospital

Ellingham hospital has the capacity to care for up to a total of 44 patients. Two wards accommodate patients aged from 5 to 18 years, and one ward is an acute ward for adults of working age.

The service is registered with CQC for assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder, or injury.

Ellingham hospital has three wards, Cherry Oak and Woodlands are Tier 4 children and adolescent wards, (CAMH) and Redwood is a ward for working age adults. There is an on- site school. The school is Ofsted registered and was rated as 'Good' in 2016.

Cherry Oak ward is a specialist 10 bedded low secure inpatient ward for patients aged from 11 to 18 years with conditions such as complex neuro-developmental disorder, learning disability, attention deficit hyperactivity disorders and mental health problems. It is a mixed gender ward and has seven funded beds. At the time of inspection there were six beds in use and all patients were detained under the Mental Health Act 1983.

Woodlands ward is a specialist inpatient ward that cares for patients aged from 12 to18 years with psychiatric, emotional, behavioural and social difficulties, including learning disabilities and autism spectrum disorder. It is a mixed gender ward and has 10 beds. At the time of the inspection, there were seven patients on the ward. Patients could be detained under the Mental Health Act or informal. At the time of inspection, all patients were detained under the Mental Health Act.

Redwood ward is an acute mental health mixed sex ward for working age adults. The ward increased its bed numbers to 24 in October 2018.The ward had 20 beds occupied at the time of the inspection. Some patients were detained under the Mental Health Act whilst others were informal.

Following a focused inspection in July 2018 the CQC issued a requirement notice against one regulation of the Health and Social Care Act. This was issued in August 2018 against Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment:

- The provider had not ensured staff carried out enhanced observations at all times as documented in the patients care plan.
- The provider had not ensured all staff understood how to report a safeguarding concern.

This outlined specific areas of concern and instructed the provider to become compliant by the end of September 2018. The provider had submitted an action plan in response to the requirement notice and had addressed the identified concerns when we checked at this inspection.

## Our inspection team

Team leader: Ricinda Mills, Inspector

The team that inspected the service comprised three CQC inspectors, an inspection manager and a specialist advisor children's and adolescent mental health nurse

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

# Summary of this inspection

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information and sought feedback.

During the inspection visit, the inspection team:

- visited the wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- undertook Mental Health Act review visits prior to inspection
- spoke with ten patients who were using the service;
- spoke with four carers of patients who were using the service;
- spoke with the registered manager and ward managers;
- spoke with 28 other staff members; including doctors, nurses, support worker, occupational therapy assistant, clinical director and support service manager;
- received feedback about the service from one commissioner;
- attended and observed three hand-over meeting, one early morning review meeting; two multi-disciplinary meetings and one patient community meeting;
- looked at twelve care and treatment records of patients;
- carried out a specific check of the medication management;
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

- Patients we spoke to told us that they felt safe at the hospital and that staff were kind and caring.
- Some patients told us that staff were sometimes too busy to do activities or spend one to one time with patients. Seven patients on Redwood Ward said there was a lack of meaningful activities. One told us they found the games too childish. Two patients told us they thought there should be more "therapy".
- We spoke to two carers who told us they were very happy with the care that was being given to their child. They told us that they felt listened to, involved with decisions about the care given to their child and kept fully up to date with their progress.
- Two patients on Redwood Ward told us the doctors and nursing staff explained information well. They felt they were included and involved in decisions about their care and treatment.
- Patients on Redwood ward were not sure whether they had a care plan but one patient told us staff talked to them informally about what support they needed whilst they were on the ward.
- On Redwood ward one patient told us the doctor used section 17 leave as a "carrot and stick". Another told us they had waited for over a month to have leave.
- Patients we spoke with on Redwood ward were positive about the environment, their bedrooms and communal areas.
- We received positive comments about the food. One patient told us the hospital catered for their specific diet.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Requires improvement 

We rated safe as requires improvement because:'

- Staff shortages, particularly for qualified staff, and high usage of bank and agency staff had an impact on staff and patients. Staff regularly did not have time to take breaks, engage in activities with children, support new staff or fully complete paperwork. Staffing was an issue for concern that had been raised at previous inspections.
- Nursing staff we asked about section 17 leave told us that section 17 leave for patients was often cancelled because of staff shortages.
- The provider had a staffing matrix to inform the level of staff required per shift. However, there were insufficient staff at times to safely carry out observations of patients and observation risks were not accurately recorded in 12 out of 13 records we reviewed on Redwood Ward. Staff told us that observation levels had been reduced at night over the preceding two weeks due to lack of staff on children's and adolescent wards (CAMHS) wards. At the last inspection we found staff had not always carried out enhanced observations as documented in the patients care plan.
- We were not satisfied that all serious incidents were being reported and reviewed by managers regularly. We did not see rigorous identification of lessons learnt following incidents. A 'lessons learned' newsletter was published but this did not demonstrate how or when actions were to be put in place, or by who. We found 69 paper incident forms not uploaded on the electronic system in a timely manner on Cherry Oak ward. Therefore, we could not be assured that managers had sufficient oversight of recent incidents and reports would contain incomplete data.
- Forms documenting incidents of violence and aggression were poorly completed on CAMHS wards. Body maps detailing any injuries were not completed, forms had incorrect pre-populated dates and notes were not counter-signed by a qualified member of staff if completed by a support worker.
- On Redwood ward, medicines bottles were not always clearly dated so staff did not know when the bottles were opened or the expiry date.

However:

# Summary of this inspection

- Staff had identified ligature points on environmental audits and these were comprehensive and up to date. Staff were aware of blind spots on the wards and these were mitigated using CCTV and convex mirrors to promote staff observation of patients. However, the ward manager on Redwood Ward was unable to locate a ligature risk assessment for the assisted daily living kitchen.
- Clinic rooms were visibly clean, tidy and fully equipped to enable staff to prepare medications and undertake physical health monitoring effectively and safely. Staff monitored and recorded the fridge and clinic room temperatures daily. Emergency grab bags containing resuscitation equipment, which were not effectively maintained at the last inspection, had all the appropriate content and had been checked weekly.
- Staff awareness of safeguarding had improved since the last inspection. The provider had good safeguarding protocols in place. Staff were aware of the safeguarding processes and how they should respond if they had concerns.
- The wards were visibly clean and well maintained. The cleaning supervisor carried out regular checks, including cleaners trolley books, to ensure all cleaning materials were fully accounted for whilst on the ward.

## Are services effective?

Good

We rated effective as **good** because:

- Care records showed that physical health examinations were completed on admission and monitored throughout treatment. A local GP attended the hospital weekly to deliver physical health advice, treatment and care.
- Supervision and appraisal rates had improved since the last inspection and staff told us that supervision was supportive and helpful in reflecting on their practise. There was a 100% appraisal rate for staff.
- A range of staff worked together as part of a multi-disciplinary team to deliver care to patients. Staff files showed that staff had the correct pre-employment checks and all staff were offered a two-week induction period, which included safeguarding and the management of violence and aggression.
- The provider had clear referral and assessment processes. Thorough pre-admission assessments were carried out to ensure Ellingham hospital was an appropriate placement.

# Summary of this inspection

- Patients had comprehensive care plans that were holistic and included easy read positive behaviour plans on CAMHS wards. Staff could find the information that they needed using the electronic systems.

However:

- The doctors providing out of hours care on CAMHS wards did not have experience or training in psychiatry and told us they did not always feel confident in responding to risk and challenging situations.
- On Redwood ward we reviewed six care and treatment record. We found five out of six care plans were holistic and recovery focused. However, personalisation was limited within the keeping well section of the care plan. This was because a generic template had been completed for five out of six records.
- On CAMHS wards none of the bank or agency staff we spoke to told us they had any specialist qualifications in child and adolescent mental health and specialist training was not offered in-house to staff. Out of hours medical cover was provided by an external agency.
- On CAMHS wards the locum social worker had not received any training in dealing with violence and aggression which could compromise her personal safety when working on the wards.

## Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients with dignity, care and respect and were familiar with each patient's care and support needs and preferences. We observed caring interactions between staff and patients and staff managing difficult situations well, maintaining patients' dignity and safety at all times.
- The carers we spoke with felt happy with the care that was being given to their family member. Carers of patients on CAMHS wards told us that they felt listened to, involved with decisions about the care given to their child and kept fully up to date with their progress.
- Independent advocates visited the wards each week and offered support with aspects of patient's care.
- On Redwood ward patients had opportunities to feedback through surveys and community meetings.
- The patients we spoke with on CAMHS told us that staff were kind and caring and they felt safe on the ward.

However:

# Summary of this inspection

- On CAMHS wards one patient told us that sometimes staff were too busy to spend one to one time with them.
- Care plans did not always demonstrate patient involvement and did not consistently evidence if these had been offered to patients. On CAMHS wards where patients had communication difficulties or lacked capacity, this was not always noted and there was no consideration demonstrated of how this information could be given in an alternative way.

## Are services responsive?

Good

We rated responsive as **good** because:

- There was a full range of rooms to support treatment and care. Patients had their own ensuite bedrooms which they could personalise in accordance with their individual risk assessments. Bathrooms all had anti-ligature magnetic doors which allowed privacy for patients whilst maintaining their safety.
- On CAMHS wards patients had individual activity schedules as part of their care plan. This included educational needs as well as physical activity. The service had an OFSTED registered school on site offering up to 18 hours a week of education for patients. Teaching staff provided ward based sessions in a dedicated schoolroom if patients did not have section 17 arrangements to leave the ward.
- The occupational therapist and activity co-ordinators provided a variety of activities both on and off the ward.
- On CAMHS wards the therapy team carried out a monthly quality walk round with an easy read questionnaire for patients to give them an opportunity to raise any concerns or complaints.
- On Redwood ward patients could make and receive phone calls in private; make drinks and snacks 24 hours a day; they had access to a garden and a range of books and board games. There were kitchens on CAHMHS wards where patients could make meals or snacks with support.
- On Redwood ward patients could keep their belongings safe in lockable cupboards within their bedrooms.
- Staff ensured that patients had access to interpreters when required.

However:

# Summary of this inspection

- Patients told us there were not enough activities at the weekend and at times section 17 leave was cancelled or delayed as there were not enough available staff to escort them.
- Patients on one male corridor on Redwood ward did not have a key to their bedrooms this was because the doors all had the same lock.
- Three out of the latest six monthly clinical governance meetings had not taken place. This reduced the opportunity for managers to review and discuss complaints and identity learning outcomes to share with all staff.

## Are services well-led?

**Requires improvement**

We rated well-led as **requires improvement** because:

- The provider had not ensured that the skills and numbers of staff on the ward met the assessed needs of patients. For example, staff raised concerns that they were understaffed and did not have enough time to take breaks, complete paperwork and support new staff. This adversely affected the care and treatment given to patients.
- Staff vacancy, sickness and turnover rates were high. There were no permanent qualified nursing staff on Redwood ward.
- On Redwood ward there was low morale amongst some staff at times and some staff reported they did not feel supported by managers.
- There was not sufficient oversight of the recording of serious incidents on CAMHS wards and we were not assured that lessons learnt were being rigorously identified and shared with all staff, including bank and agency staff.
- Only three out of the six planned clinical governance meetings had taken place over the past six months. This meant that clinical governance processes were not fully embedded.
- We were concerned that the hospital continued to admit patients without assurance of being able to provide appropriate numbers of staff.

However:

- Staff knew the provider's whistleblowing policy and said that they were confident to raise concerns without the fear of reprisals.
- The provider's mission statement was 'the five principles that underpin our working with young people – nurture, expectations, respect, enabling and reflection'. We saw that staff demonstrated the provider's values in their care and approach towards the patients.

# Summary of this inspection

- Staff knew who the senior managers were on site and confirmed that the senior management team visited the wards regularly and spoke with patients and staff during these visits.
- The provider had worked hard on recruitment to improve staffing and this had resulted in fewer vacancies amongst support workers.

# Detailed findings from this inspection

## Mental Health Act responsibilities

- On Woodlands ward, 88% of staff were up to date with training in the Mental Health Act and 87% on Cherry Oak ward.
- On Redwood ward 84% of eligible staff were up to date with training in the Mental Health Act.
- There was a Mental Health Act administrator based on the hospital site.
- We reviewed Mental Health paperwork on all wards and paperwork was complete and in order. Approved mental health professional (AMHP) reports were available for each patient.
- An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints.
- Patients did receive information about their legal status and rights in line with the requirements of the Mental Health Act section 132 and the Mental Health Act Code of Practice.
- On Redwood ward staff displayed a notice reminding informal patients of their right to leave the ward. They explained informal patients' rights in more detail during the admission process.
- Staff displayed a range of information posters around the ward, including the complaints process and how to obtain easy read factsheets about the Mental Health Act.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- On Woodlands ward, 71% of staff were up to date with training in the Mental Capacity Act and 93% on Cherry Oak ward. The responsible clinician assessed patient's capacity or competence to consent to treatment at the time of their admission and at regular intervals where necessary.
- Staff we spoke with demonstrated good understanding of mental capacity and how this was assessed on an ongoing basis.
- On Redwood ward we saw within records reviewed staff documented that patients had capacity assessments relating to their consent to agree to their initial care plan on admission to the ward. The Responsible Clinician assessed the patient's capacity to consent to treatment each week.
- VoiceAbility provided the independent mental health advocacy (IMHA) service. Managers told us the advocate visited the ward each week. Staff talked to patients about their right to see an advocate and automatically referred patients who lacked capacity to make that decision.

## Overview of ratings

Our ratings for this location are:

# Detailed findings from this inspection

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Acute wards for adults of working age and psychiatric intensive care units | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Child and adolescent mental health wards | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Overall | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |

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

Requires improvement

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires improvement |

## Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

**Safe and clean environment**

- The ward had numerous blind spots and points that could be used to self-ligature. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Managers had identified these risks and the hospital had installed mirrors and closed-circuit television (CCTV) to aid staff's observation of patients and mitigate the risk of potential harm to patients. Staff had access to ligature cutters in the event of needing these. Ligature risk assessments had been completed for the ward. These were dated 28 December 2018. Managers confirmed mitigating action was to accompany patients and we saw mitigation plans within the ligature risk assessments to confirm this. However, the ward manager was not able to locate all the risks within the ligature risk assessments for example the Assisted Daily Living kitchen. This was because there was not a combined assessment for the whole ward, there was a single document for each room in the ward. Because of the large number of rooms this was cumbersome and meant that staff could not quickly identity risks and know what action to take to reduce the risk.
- There was an environmental heat map of the ward area on the wall in the ward office. The map showed risks in the ward environment which were colour coded to show low, medium and high-risk areas. Managers told us that patients were allocated to bedrooms according to the level of the individual patient risk and access to spaces were risk assessed.
- The ward provided care for both male and female patients. There was three bedroom corridors, two male and one female. These were separate corridors so males and females did not need to walk through other corridors. All 24 bedrooms had ensuite facilities with toilet, basin and shower. There was one bathroom in a communal area which could be used by either male or female patients under supervision. There were no mixed sex breaches.
- The ward had one lounge for use by both male and female patients and a female only lounge,
- The support service manager ensured a maintenance check took place daily via a quality walk round. We viewed the maintenance log and there was a site improvement plan in place. We saw an improvement in the ward environment since the previous inspection. The hospital employed a house keeper. All areas on the ward were clean and tidy.
- Kitchen fridges were clean and food labelled correctly. There were records to monitor the fridge temperature.
- We found the clinic room to be clean and tidy. However, we were unable to locate the cleaning audit. Therefore, we were not assured that staff were aware of any actions arising from the audit. Staff recorded emergency equipment had been checked.

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

Requires improvement

- Staff had access to personal alarms for use in an emergency. However, safety alarms were not routinely offered to inspectors during the inspection. There was nurse call alarms for patients.

**Safe staffing**

- The provider informed us that the ward had a high staffing vacancy rate. Data for November 2018 showed the vacancy rate for qualified nurses was 100%. The vacancy rate for support workers was 33%. At the time of inspection, the ward did not have any permanent nursing staff. The ward manager was the only permanent registered nurse on the ward team. We viewed rotas which showed that bank and agency nursing staff were used to fill all shifts as a minimum of two qualified nursing staff was required. The day and night shifts were led by agency nurses who worked at the hospital regularly and were familiar with the service. Managers confirmed gaps in staffing were filled by bank and agency staff. The ward manager confirmed recruitment into these vacant posts was ongoing.
- Managers told us they could adjust the number of staff required to cover shifts based on the clinical needs of patients. Managers attended early morning meetings to review the number of staff needed for that day. However, the provider did not deploy sufficient staff to ensure patients were managed safely. Staffing rotas confirmed that not all shifts were filled.
- A staffing matrix was in place which stated the minimum number of qualified and unqualified staff needed on the ward. However, we were concerned that this calculation did not meet the needs of the patients. Staff told us they did not always have time for a break which meant that they did not comply with the hospital policy on observations. Staff told us they sometimes struggled to observe all patients on intermittent observations due to the high patient staff ratio. The observations book showed that on some occasions one staff member was supporting 14 patients on intermittent observations. Managers confirmed that it could be challenging finding additional staff to cover enhanced observations in response to ward acuity and availability of staff to support this. Staffing on the ward for 9 January 2019 was two registered nurses and six support workers for 20 patients. At this time, four patients were on 1:1 observations. Managers acknowledged that this was insufficient given the level of acuity on the ward. We viewed the staffing rota and found between 1 to 9 January 2019, 10 of the 17 available shifts were not filled. We were therefore not assured that staff could carry out safe observations of patients. We viewed minutes of staff meetings which indicated that shortage of staff was a theme for discussion. The provider did not provide sufficient staff to ensure patients accessed escorted leave in accordance with what had been agreed with them. This was supported by section 17 paperwork. Members of the multidisciplinary team stepped in to support this when they were able. However, staff and patients told us patients' leave off the ward was regularly cancelled or delayed. This meant that patients did not always have an opportunity to leave the ward when requested.
- Information regarding staffing levels for the day was not displayed for patients to see.
- The ward had adequate numbers of medical cover day and night. Medical treatment was provided by one consultant psychiatrist, who is the responsible clinician, and a ward doctor. This meant that patients could access medical support when required.
- There had been an improvement in the overall compliance for mandatory training courses. The total compliance rate was 84%. Of the 18 mandatory training courses two failed to score above 75%. These were Data Protection and Confidentiality (71%) and Moving and Handling (71%).

**Assessing and managing risk to patients and staff**

- Staff completed a comprehensive risk assessment of patients prior to admission to the hospital. This included both historic and current risks. We reviewed six care records and found evidence that risk assessments took place within 24 hours of admission.Staff reviewed risk assessments weekly during multi-disciplinary team (MDT) meetings and after incidents. We observed the early morning handover, where staff discussed recent incidents and changes to patients' risk management plans.
- The ward did not have a seclusion room. However, managers told us at times patients were secluded in their bedrooms whilst awaiting transport for a transfer to a psychiatric intensive care ward. Staff advised that in those cases they implemented the hospital's seclusion policy and carried out the required monitoring. None of

the patients on the ward at the time of our visit had been secluded, therefore we did not review any records. We reviewed the seclusion log which was dated from 1 October 2018 and there had been no episodes of seclusion on Redwood Ward.

- Between 1 April 2018 and 30 September there were 13 incidents of restraint (on 7 different service users) none of these were prone restraints. Staff carried out physical restraint appropriately and as a last resort. Staff, including bank and agency staff, received prevention and management of aggression training. The ward manager was the trainer for this. A training session took place as part of the induction programme during the inspection.
- We were not assured that the enhanced observations were carried out safely. The provider policy for observations and engagement said that staff must not be continuously on 1:1 observations for more than two hours. Staff said that this was not always possible as there was often a high level of patients requiring observations. This included multiple staff observations where a patient required more than one staff with them. For example, on one occasion one staff member was supporting 14 patients on intermittent observations. We reviewed 13 observation records. Twelve did not identify the individual patient risk. This meant that staff carrying out observations may not be aware of the reason for the observation level. However, the records were signed as complete. We found that the daily allocation sheets in the ward office did not accurately reflect the patient numbers. For 9 January 2019 this listed 18 patients however there were 20 on the ward. One patient was on leave. This meant that observations may not be known and therefore carried out safely. We raised this at the time and it was rectified immediately.
- We reviewed 13 observation records. Twelve did not identify the individual patient risk. This meant that staff carrying out observations may not be aware of the reason for the observation level. However, the records were signed as complete.
- There were no blanket restrictions in place on the ward.

**Safeguarding.**

- Staff awareness of safeguarding had improved since the last inspection. The provider had good safeguarding protocols in place. Staff were aware of the safeguarding processes and how they should respond if they had concerns. Staff told us who they would report safeguarding concerns to. They knew the local safeguarding procedure and understood their responsibilities about reporting concerns.
- The ward manager was the adult safeguarding lead and the clinical director was the safeguarding lead for the hospital. We saw the safeguarding referral process clearly displayed in the ward office.
- The safeguarding lead nurse held monthly meetings with the local multi-agency safeguarding hub (MASH).
- Records showed 93% of eligible staff had received safeguarding adults training and 93% of eligible staff had received safeguarding children training.
- There had been 16 safeguarding referrals in the past six months.

**Medicines management**

- We reviewed six medication charts and found that these had the relevant consent to treatment and that medicines information had been provided to the patient. We saw that electrocardiogram (ECG) tests were taken on admission and recorded. We found no errors on the medication charts. However, we found one signature omission which had been identified by the pharmacist as part of their audit.
- Medicines including controlled drugs, emergency medicines and medical gases were stored securely. However, we found two bottles open which were undated this meant that staff did not know the expiry date. We found three bottles where the date had expired.
- Emergency medicines and equipment were accessible to staff and staff checked these regularly.
- Staff monitored the temperatures of medicine storage fridges.
- Regular audit was undertaken by the contracted pharmacist and any actions identified were addressed. We viewed the audit and found it to be up to date and complete.

**Track record on safety**

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

Requires improvement

- Between 1 April 2018 and 30 September 2018, the ward reported 18 serious incidents. The nature of these incidents included episodes of physical aggression and patient on patient abuse.

**Reporting incidents and learning from when things go wrong**

- Staff knew how to complete incident report forms on the provider's electronic reporting system. Staff described their role in the reporting process and were able to give examples of learning from incidents.
- Staff told us they discussed incidents and learning points in team meetings. We observed incidents was a standing agenda item at staff meetings and clinical governance meetings. However, three out of the latest six monthly clinical governance meetings had not taken place and staff meeting minutes did not routinely include learning and actions. This reduced the opportunity for managers to review and discuss serious incidents and identity learning outcomes to share with all staff.
- Managers told us they attended monthly lessons-learned meetings where incidents were reviewed. A 'lessons learned' newsletter was published. We saw an example of a lessons learnt bulletin for September 2018. However, this did not demonstrate when actions were to be put in place, or who took ownership for implementation.
- Managers and staff confirmed debrief meetings with staff and patients took place after incidents occurred.

## Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

- The provider had clear referral and assessment processes. Assessments were comprehensive and included both current and historical information.
- Care records showed that physical health examinations were completed on admission and monitored throughout treatment. A local GP attended the hospital weekly to deliver physical health advice, treatment and care. Access was available to other specialist physical health professionals in the community.
- An external pharmacy service visited each ward weekly to check and monitor medication stocks, records and to remove excess medications for disposal.
- We reviewed six care and treatment records. We found five out of six care plans were holistic and recovery focused. However, personalisation was limited within the keeping well section of the care plan. This was because a generic template had been completed for five out of six records.

**Best practice in treatment and care**

- ·Staff supported patients to access specialists when required for physical healthcare needs. Appointment with specialists were discussed at the early morning review meetings.
- There was a healthcare audit plan in place for 2018/ 2019. Audits included; ligatures; infection control, schizophrenia, Mental Health Act, safeguarding, clinical supervision, risk assessment and Mental Capacity Act and consent.

**Skilled staff to deliver care**

- A range of staff worked together to deliver care to patients. We reviewed six staff files that showed that staff had the correct pre-employment checks and all staff were offered a two-week induction period, which included safeguarding and the management of violence and aggression.
- We viewed 11 agency profiles that showed that agency staff had the skills needed to provide patient care.
- Supervision and appraisal rates had improved since the last inspection and Staff confirmed they had regular clinical supervision and appraisals. Records showed the overall appraisal rate for staff on 8 January 2019 was 100%. Eighty one percent of staff received clinical supervision during December 2018.
- All health care assistants were required and supported to take the care certificate. The care certificate covers a national set of standards that unqualified staff should achieve during a period of induction to care work.

**Multi-disciplinary and inter-agency team work**

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

Requires improvement

- The multidisciplinary team consisted of a consultant, doctor, qualified nurses, nursing assistants, occupational therapist, assistant psychologist and two activities co-ordinator. However, at the time of our inspection there was no input from a psychologist or speech and language therapist. Managers told us there was ongoing recruitment to these roles. The ward had recruited into the occupational therapy post, which became vacant in December 2018. Two activity coordinators worked across the three wards at Ellingham Hospital.
- We attended an early morning handover meeting where the multi-disciplinary team discussed recent incidents, patient's risks, and changes to care plans.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

- There was a Mental Health Act administrator based on the hospital site.
- Patients did receive information about their legal status and rights in line with the requirements of the Mental Health Act section 132 and the Mental Health Act Code of Practice.
- Staff displayed a notice reminding informal patients of their right to leave the ward. They explained informal patients' rights in more detail during the admission process.
- VoiceAbility provided the independent mental health advocacy (IMHA) service. Managers told us the advocate visited the ward each week. Staff talked to patients about their right to see an advocate and automatically referred patients who lacked capacity to make that decision. There was information on the notice board about the role of the advocate, which included contact details for patients wishing to self-refer.
- Staff displayed a range of information posters around the ward, including the complaints process and how to obtain easy read factsheets about the Mental Health Act.
- Records showed Mental Health Act training compliance was 84%

**Good practice in applying the Mental Capacity Act**

- The responsible clinician assessed patient's capacity or competence to consent to treatment at the time of their admission and at regular intervals where necessary.
- Records showed Mental Capacity Act training compliance was 86%

## Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

**Kindness, privacy, dignity, respect, compassion and support**

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients and saw that staff were considerate and respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities.
- Staff spoken with expressed commitment to their role. Carers spoken with confirmed that staff were helpful and friendly. Patients spoke positively about staff.

**Involvement in care**

- Staff encouraged patients to complete a feedback survey upon discharge. We saw in clinical governance meeting minutes that surveys were centrally collated, however there was limited discussion as to how feedback is disseminated to staff. Patients had opportunities to give feedback about the service, raise concerns and make suggestions for change during community meetings. Prior to October 2018 these were infrequent but this had improved since then and the staff team aimed for a meeting each week. Issues raised by patients were carried over to the next meeting but staff did not always record what action, if any, they had taken. An example of action taken following feedback was more board games were requested and purchased.
- We reviewed six care plans. Five of the six plans showed evidence of patients' involvement. However, three patients we spoke with told us they had not been offered a copy of their care plan.
- Records included patients' wishes regarding sharing information with their carers. Staff recorded patients'

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

Requires improvement

wishes about involvement and information sharing with carers. However, the nurse told us they would still request the patient's permission before disclosing any information.

- Independent advocates visited the wards each week and offered support with aspects of patient's care including Mental Health Act tribunals and making complaints. We saw information available contained in patient admission packs and on posters and leaflets available on the wards.
- Carers spoken with told us that staff kept them up to date on the care of their family members and were happy with the care and treatment.

**Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?** (for example, to feedback?)

Good

**Access and discharge**

- Managers told us that patients were usually admitted to the ward when there were no beds available in their local NHS area. The patients' local clinical commissioning groups (CCG) funded the placements. The ward team liaised with the patients' local hospital and community teams to discuss treatment and provide updates about progress. Over the last six months 92 patients were admitted with a home address of at least 50 miles into the service. However, managers told us when a bed becomes available patients are transferred back to their own area.
- Referrals for admission were triaged centrally by the Priory organisation. The consultant psychiatrist and the nurse in charge assessed the referrals for Redwood ward and decided about the suitability of the patient.
- Patients were admitted at any time and staff told us there was a high percentage of admissions during the night. Admissions were usually emergency and short notice. At times, this put pressure on the night shift staff when there was high acuity of patients already on the ward or the ward was short staffed.
- There was no Psychiatric Intensive Care Unit (PICU) on the ward. Managers informed us that patients requiring a PICU bed were transferred out of service. In the past six months no patients have waited more than 12 hours for a PICU bed once the decision to transfer has been made.
- Managers confirmed expected length of stay was one month. Between 1 October 2017 and 30 September 2018, the average length of stay was 22.5 days.
- Bed occupancy for the ward on 8 January 2018 was 83%.

**The facilities promote recovery, comfort, dignity and confidentiality**

- Patients had their own bedrooms with ensuite shower and toilet facilities. There was a separate bathroom which was locked as staff could not clearly observe the patient in the area. Patients could request to use the bathroom with a member of staff.
- There were sufficient rooms for patients to access individual sessions with nursing staff, to receive visitors or to participate in ward based activities. The ward had one lounge for use by both male and female patients. The remainder of the communal space included a female only lounge, two dining rooms, a meeting room, activity/therapy rooms a quiet room and a visitor's lounge.
- Patients had access to a range of games and books. Patients could make hot and cold drinks and snacks 24 hours a day. There was an activity kitchen where patients can make drinks and snacks under staff supervision. In addition, there was equipment for patients to make drinks in the lounges.
- Patients had use of their mobile phones and the ward had two mobile phones that patients without phones could use to make and receive calls.
- There were multiple ligature risks in the garden. Staff mitigated these risks by accompanying patients in the outside area. This meant that patients could not access the garden unless accompanied.
- Patients' valuables were kept in lockers either within locked cabinets in their bedrooms or locked containers within rooms accessible only by staff.

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

Requires improvement

- We saw bedroom doors with viewing panels to enable patient observations. The panels could be open and closed by staff and patients. However not all bedroom doors on the male corridor had viewing panels.
- Most patients had keys to access their bedrooms themselves. However, one of the male bedroom corridors did not have keys. This was raised in community meetings and had been investigated by staff. However, the ward manager advised they were unable to supply individual keys because the locks were the same on all the doors. The ward manager told us they are in the process of reviewing options to address this.
- There were no restrictive interventions on the ward.

**Meeting the needs of all people who use the service**

- Patients had access to a range of information leaflets in ward areas. For example, information of advocacy, patients' rights, how to complain and activity provision.
- Staff had access to interpreters to enable communication with patients, as needed. However, the ward manager did not know if written information was available for patients whose first language was not English.
- We saw a weekly timetable of activities advertised on the ward. However, patients told us there were not enough activities in the evening and weekend, as therapy staff were not available and nursing staff were often too busy to do activities with them.

**Listening to and learning from concerns and complaints**

- Patients had access to information on how to make a complaint. Wards had information on the complaints process and this was displayed to patients on ward notice boards and in leaflets. The hospital had systems for the recording and management of complaints.
- Between 1 April 2018 and 30 September 2018, 14 complaints were made to Redwood Ward. Examples of complaints included, staff communication; complaints about other patients and observations not being carried out as prescribed. When staff received a complaint, they wrote to the complainant to acknowledge receipt of the complaint and explained the process.
- Between 1 September and 30 September 2018, the ward received 15 compliments. We saw examples of these.
- Three out of the latest six monthly clinical governance meetings had not taken place. This reduced the opportunity for managers to review and discuss complaints and identity learning outcomes to share with all staff.
- Patients raised concerns and provided feedback about the wards at daily community meetings. Minutes of the meetings showed that actions had been taken as a result of feedback. For example, more board games had been provided.

## Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

**Vision and strategy**

- The provider's mission statement was 'the five principles that underpin our working with young people – nurture, expectations, respect, enabling and reflection'. We saw that staff demonstrated the provider's values in their care and approach towards the patients.

**Governance**

- The provider had not ensured that the skills and numbers of staff on the ward met the assessed needs of patients. For example, staff raised concerns that they were understaffed and did not have enough time to take breaks, complete paperwork and support new staff. This could adversely affect the care and treatment given to patients.
- We were not assured that lessons learnt were being rigorously identified and shared with all staff, including bank and agency staff.
- Only three out of the six planned clinical governance meetings had taken place over the past six months. This meant that clinical governance meetings were not fully embedded, and we could not be assured that lessons were being learnt.
- Compliance with mandatory training had improved since the last inspection and the overall rate was 84%.

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

Requires improvement

- Supervision and appraisal rates had improved since the last inspection. There was now a 100% appraisal rate for staff.
- Staff demonstrated clear understanding of safeguarding and Mental Health Act procedures.
- We found inconsistencies within the medication audit. There were bottles of medicines that were past their expiry dates. This information did not corroborate with the dates recorded within the medicines audit.

**Leadership**

- Staff knew who the senior managers were on site and confirmed that the senior management team visited the wards regularly and spoke with patients and staff during these visits.
- Staff knew the provider's whistleblowing policy and said that they were confident to raise concerns without the fear of reprisals.
- Staff cited cohesive, strong team working and peer support as factors in enabling them to provide care and treatment to patients. However, staff told us that morale was low at times due to staffing and workload pressures and some staff told us that they did not feel recognised or supported by senior staff.
- The Provider had worked hard on recruitment to improve staffing and this had resulted in fewer vacancies amongst support workers. However, staff turnover and sickness rates remained high. Sickness absence rates for permanent staff for the period between 1 October 2017 and 30 September 2018 was 60%. Between 1 October 2017 and 30 September 2018, the staff vacancy rate for the ward was 35%. We were concerned that the hospital continued to admit patients without assurance of being able to provide appropriate numbers of staff to meet patient need.

Requires improvement

# Child and adolescent mental health wards

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires improvement |

## Are child and adolescent mental health wards safe?

Requires improvement

### Safe and clean environment

- Staff had identified ligature points on environmental audits and these were comprehensive and up to date. Woodlands ward had completed their most recent ligature audit in December 2018 and there were plans to discuss them at forthcoming team meetings as part of the 'policy of the month' agenda item.
- There was comprehensive CCTV coverage of all communal areas of the wards as the hospital had employed an external company to provide 24-hour CCTV monitoring. Some patient bedrooms were also monitored by CCTV where consent had been given and/or the responsible clinician had deemed this to be in the best interest of the patient as part of the risk assessment and care planning process. We observed family involvement and assurance policy and procedures for this practise.
- Staff were aware of blind spots on the wards and these were mitigated using CCTV and convex mirrors to promote staff observation of patients.
- Wards complied with the Department of Health's eliminating mixed sex accommodation guidance, which meant that the privacy and dignity of young people was upheld.
- Clinic rooms were visibly clean, tidy and fully equipped to enable staff to prepare medications and undertake physical health monitoring effectively and safely. Staff monitored and recorded the fridge and clinic room temperatures daily. Emergency grab bags containing resuscitation equipment, which were not effectively maintained at the last inspection, had all the appropriate content and had been checked weekly.
- The seclusion room on Cherry Oak met the required standards as outlined in the Mental Health Act 1983 Code of Practice 2008. The viewing panel had been replaced following a requirement from the last inspection to ensure clear lines of sight, and a working clock was in place.
- The wards were visibly clean and well maintained. The cleaning supervisor carried out regular checks, including cleaners trolley books, to ensure all cleaning materials were fully accounted for whilst on the ward.
- The physical environment of the wards was bland and institutional and did not reflect the age of the children and young people. One ward manager told us there was a budget and plan in place to improve this, by putting up patients' artwork for example. However, they had not had the time to action this.
- Staff carried radio alarms to summon help when needed and these were kept charged regularly. Patients had access to nurse call buttons and approached staff if needing assistance. However, inspection staff were not offered personal alarms at any point during the inspection visit.

### Safe staffing

- Staff recruitment was challenging for this service. Staff shortages, particularly for qualified staff, and high usage of bank and agency staff had an impact on staff and patients. At the time of inspection, Cherry Oak ward had

seven vacancies for qualified staff and Woodlands had three vacancies for qualified staff and 0.2 vacancies for support workers. Between 1 October 2017 and 30September 2018, the staff sickness rate was high at 30% on Cherry Oak ward and 56% on Woodlands ward.

- A staffing matrix was in place which stated the minimum number of qualified and unqualified staff needed on the wards. However, we were not assured that these minimum numbers matched the actual need because of the acuity of the patients on the unit and because of the consistently high levels of sickness and staff turnover.
- Managers used bank and agency staff to cover sickness and absence. However, at the time of inspection, there were 13 unfilled shifts during the preceding two weeks on Woodlands ward and 15 unfilled shifts on Cherry Oak ward.
- We spoke with 13 members of nursing staff and they all told us that staff shortages meant that they did not have time to engage in activities with children, support new staff, take breaks or fully complete paperwork. We also observed that staff shortages were a constant theme in staff meeting and governance minutes.
- All the nursing staff we spoke with told us that section 17 leave for patients was often cancelled because of staff shortages. However, care plans stated that patients should have their leave as planned.
- One member of staff told us that observation levels had been reduced at night over the preceding two weeks due to lack of staff.
- We spoke with two patients on Woodlands ward. Both patients felt there was not enough staff which affected their ability to have one to one time with their keyworker or named nurse. One patient told us there was not enough to do at weekends and evenings because staff did not have time to do activities with them.
- Supervision rates and compliance with mandatory training had improved and there was an overall compliance rate of 75% for Woodlands ward and 83% for Cherry Oak. However, compliance rates for infection control on both CAMHS wards remained below the providers target of 85%.

**Assessing and managing risk to patients and staff**

- Staff completed a comprehensive risk assessment of patients prior to admission to the hospital. This included both historic and current risks. We reviewed six care records and found that staff reviewed risk assessments weekly during multi-disciplinary team (MDT) meetings and after incidents. We observed the early morning handover, where staff discussed recent incidents and changes to patients' risk management plans.
- We were satisfied that physical restraint and seclusion were being used appropriately and as a last resort. Staff, including bank and agency staff, received prevention and management of aggression training, although this was not specifically for young people. Patients had easy read positive behaviour support plans which entailed a management plan of triggers, for example, to prevent or reduce the use of restraining.
- In the four 'managing violence and aggression' (MVA) incident forms we reviewed in CAMHS wards, all had incomplete body maps detailing injuries that had occurred. Forms had pre-populated dates which were then incorrect, and notes were not counter-signed by a qualified member of staff if completed by a support worker.
- We looked at four sets of seclusion records. The records were clear. Observations and reviews were completed in line with recommendations outlined in the MHA Code of Practise. On one occasion the attending doctor did not arrive within one hour as specified in the code of conduct.
- The doctors who covered the wards out of hours were locum doctors trained in general medicine with no training or experience in psychiatry or child and adolescent mental health. We were told that this presented a challenge for them in trying to learn the system and with managing challenging patients and reviewing risk. However, they told us they had good support from the nursing team and senior doctors were easily accessible for advice.
- One member of staff told us that observations had been reduced over the preceding two weeks due to inadequate staffing levels at night. This meant we were not assured that the enhanced observations were carried out safely across both wards.

**Safeguarding**

- Staff awareness of safeguarding had improved since the last inspection. The provider had good safeguarding protocols in place. Staff were aware of the safeguarding processes and how they should respond if they had concerns. Staff told us who they would report safeguarding concerns to. They knew the local safeguarding procedure and understood their responsibilities about reporting concerns. Records showed that 76.6% of staff on Woodlands and 86.7% of staff on Cherry Oak had completed safeguarding children training.

**Medicines management**

- We reviewed six prescription cards. There was effective medicine management. Staff stored medicines in accordance to the manufacturers' guidelines. Prescriptions were written in line with British National Formulary guidance and recorded alerts for young people' allergies. Medicines were disposed of appropriately.
- Staff recorded the temperature of the clinic room and refrigerator daily, to ensure the temperature did not affect the efficacy of the medication.
- Regular audit was undertaken by the contracted pharmacist and any actions identified were addressed.
- Not all prescription charts had a photograph of the patients attached which can help avoid identification errors for staff not familiar with the patient. Charts had inconsistent information regarding risk, capacity and consent to treatment.

**Track record on safety**

- The provider reported serious incidents on the E: Compliance electronic incident system. Managers provided figures for serious incidents over the 12 months prior to inspection. Cherry Oak had reported 13 serious incidents and Woodlands ward had reported 10 incidents. The nature of these incidents included episodes of physical aggression, self-harming, patient on patient abuse and allegations of staff abuse.

**Reporting incidents and learning from when things go wrong**

- Staff knew how to report incidents on the provider's electronic reporting system. Staff could either report directly onto the electronic recording system or onto a paper form if they could not access the electronic recording system at the time.
- We were not satisfied that all serious incidents were being reported and reviewed by managers regularly. On Woodlands ward, we found 69 paper incident forms which had not been uploaded on to the electronic system. We observed, in team meeting minutes, that a member of staff raised the difficulty of staff not having enough time to input incidents in a meeting on Cherry Oak ward in October. Clinical governance meeting minutes from November 2018 stated there were 41 incidents not notified on Cherry Oak, there were duplications in reporting and there were no lessons learnt.
- Three out of the latest six monthly clinical governance meetings had not taken place. This reduced the opportunity for managers to review and discuss serious incidents and identity learning outcomes to share with all staff.
- We could not see evidence of rigorous identification and sharing of lessons learnt. Ward meeting minutes from Cherry Oak and Woodlands did not show evidence of discussion and learning from serious incidents. A 'lessons learned' newsletter was published but this did not demonstrate how or when actions were to be put in place, or by who. For example, the November newsletter noted that observations were not being carried out correctly, but there were no details of how this was going to be rectified. Three staff we spoke to were not able to tell us what lessons were learned from a recent incident where a patient went missing for several hours.
- Managers supported staff following serious incidents and staff told us they were offered debrief sessions.
- The provider had placed posters describing the Duty of Candour obligations in communal areas of the Hospital for all to read. Staff knew the importance of being open and transparent with patients, their carers and family. One parent told us that she felt staff were always open and honest about their loved one's care and discussed incidents when things went wrong.

Requires improvement

# Child and adolescent mental health wards

## Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

### Assessment of needs and planning of care

- The provider had clear referral and assessment processes. Thorough pre-admission assessments were carried out to ensure Ellingham hospital was an appropriate placement for the young person including consideration of the complexity and support needs of the existing patients. This included home visits when appropriate. Assessments were comprehensive and included both current and historical information.
- Care records showed that physical health examinations were completed on admission and monitored throughout treatment. A local GP attended the hospital weekly to deliver physical health advice, treatment and care. Access was available to other specialist physical health professionals in the community.
- An external pharmacy service visited each ward weekly to check and monitor medication stocks, records and to remove excess medications for disposal.
- Patients had comprehensive care plans that were holistic and included easy read positive behaviour plans, and staff were able to find the information that they needed. One ward manager told us that as they were still moving from one care planning system to another, there was still some work to be done in streamlining care plans, but this did not affect the quality of the information available to staff.

### Skilled staff to deliver care

- A range of staff worked together to deliver care to patients. Staff files showed that staff had the correct pre-employment checks and all staff were offered a two-week induction period, which included safeguarding and the management of violence and aggression.
- Supervision and appraisal rates had improved since the last inspection and staff told us that supervision was supportive and helpful in reflecting on their practise. Cherry Oak and Woodlands both have an 100% appraisal rate for staff. Seventy three percent of staff received clinical supervision during December 2018 on CAMHS wards.
- All health care assistants were supported and encouraged to take the care certificate. The care certificate covers a national set of standards that unqualified staff should achieve during a period of induction to care work.
- None of the bank or agency staff we spoke to told us they had any specialist qualifications in child and adolescent mental health and specialist training was not offered in-house to staff. Out of hours medical cover was provided by an external agency. Neither of the doctors providing out of hours care had experience or training in psychiatry and told us they did not always feel confident in responding to risk and challenging situations.
- The locum social worker had not received any training in dealing with violence and aggression which could compromise her personal safety when working on the wards.

### Multi-disciplinary and inter-agency team work

- Staff worked as part of a multi-disciplinary team, which included doctors, nurses, mental health support workers, an occupational therapist, activity co-ordinators, a play therapist and a family therapist. The social worker position was currently covered by a locum and recruitment was underway to replace the vacant speech and language therapist, psychologist and assistant psychologist posts.
- Staff attended early morning handover meetings where they discussed recent incidents, patient's risks, and changes to care plans. School and hospital staff worked in a joined-up way to offer the best outcomes for patients.

### Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- On Woodlands ward, 88 % of staff were up to date with training in the Mental Health Act and 87% on Cherry Oak ward.

Requires improvement

# Child and adolescent mental health wards

- We reviewed Mental Health paperwork on Cherry Oak and Woodlands ward and paperwork was complete and in order. Approved mental health professional (AMHP) reports were available for each patient.
- An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints.

**Good practice in applying the Mental Capacity Act**

- The responsible clinician assessed each patient's capacity or competence to consent to treatment at the time of their admission and at regular intervals.
- Staff we spoke with demonstrated good understanding of mental capacity and how this was assessed on an ongoing basis.

## Are child and adolescent mental health wards caring?

Good

**Kindness, privacy, dignity, respect, compassion and support**

- Staff treated patients with dignity, care and respect and were familiar with each patient's care and support needs and preferences. We observed caring interactions between staff and patients and we observed staff managing difficult situations well, maintaining patients' dignity and safety at all times.
- Staff expressed commitment to their role and viewed their patients' welfare and needs as paramount.
- The parents we spoke with felt that staff were kind and respectful and were very happy with the care that was being given to their child. They told us that they felt listened to, involved with decisions about the care given to their child and kept fully up to date with their progress.
- The patients we spoke with told us that staff were kind and caring and they felt safe on the ward. One patient told us that sometimes staff were too busy to spend one to one time with them.
- A family therapist was available who offered one to one sessions with families at a time that was convenient for the family.

**Involvement in care**

- Woodlands ward had just started offering community meetings again, after these had lapsed, to give patients an opportunity to discuss issues on the ward that affected them or changes they would like to see.
- Care plans did not always demonstrate patient involvement and did not consistently evidence if these had been offered to patients. Where patients had communication difficulties or lacked capacity, this was not always noted and there was no consideration demonstrated of how this information could be given in an alternative way.

## Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Good

**Access and discharge**

- Ellingham hospital has 20 beds for children and adolescents and admitted patients from across the country.
- Patients were assessed and admitted to the appropriate ward according to their needs and not moved from that ward unless there was a clinical reason for doing so.
- The average length of stay was 306 days on Woodlands ward and 196 days on Cherry Oak ward. This represented the complexity of the patient 's needs. Staff began planning for discharge at the point of admission. Due to the complex presentation of some patients it was not always easy to find appropriate placements to discharge to in their local communities. The responsible clinician told us this could potentially delay discharge. There were appropriate discharge plans in place for patients.

**The facilities promote recovery, comfort, dignity and confidentiality**

Requires improvement

# Child and adolescent mental health wards

- There was a full range of rooms to support treatment and care. There were large communal areas as well as smaller quiet and activity rooms including kitchens where patients could make meals or snacks with support. The clinic rooms were fully equipped with an examination couch and physical health monitoring equipment.
- Patients all had their own ensuite bedrooms which they were able to personalise in accordance with their individual risk assessments. Bathrooms all had anti-ligature magnetic doors which allowed privacy for patients whilst maintaining their safety.
- Patients had individual activity schedules as part of their care plan. This included educational needs as well as physical activity. The service had an OFSTED registered school on site offering up to 18 hours a week of education for patients. The school had been inspected by OFSTED and had a rating of good in 2016. Patients received weekly keyworker sessions to review their education. Teaching staff provided ward based sessions in a dedicated schoolroom if patients did not have section 17 arrangements to leave the ward
- Patients and staff told us that section 17 leave was often cancelled or delayed due to lack of staff.

**Meeting the needs of all people who use the service**

- The bedrooms were in separate male and female areas and there were male and female lounges.
- The occupational therapist and activity co-ordinators provided a variety of activities both on and off the ward. These were mainly individual activities, due to the needs of the current patients, and included trips off the ward and visits from a Pets As Therapy (PAT) dog. Patients are given an easy read version of their activity plan.
- The environment met the needs of patients who had physical disabilities with good access to living space and outside areas.
- Patients told us there were not enough activities in the evening and weekend, as therapy staff were not available and nursing staff were often too busy to do activities with them. We were told that consideration was being given to extend the activity coordinator role to Saturdays in the future but there were no finalised plans for this.

**Listening to and learning from concerns and complaints**

- The clinical service manager and mental health act administrator led on managing complaints. When staff received a complaint, they wrote to the complainant to acknowledge receipt of the complaint and explain the process. Other staff we spoke to said that they knew how to support patients to make complaints.Staff received feedback from complaints via supervision and staff informed patients via patient forum meetings. No second stage complaints had been to the Ombudsman.

## Are child and adolescent mental health wards well-led?

Requires improvement

**Vision and strategy**

- The provider's mission statement was 'the five principles that underpin our working with young people – nurture, expectations, respect, enabling and reflection'. We saw that staff demonstrated the provider's values in their care and approach towards the patients.

**Good governance**

- The provider had not ensured that the skills and numbers of staff on the ward met the assessed needs of patients. For example, staff raised concerns that they were understaffed and did not have enough time to take breaks, complete paperwork and support new staff. This could adversely affect the care and treatment given to patients.
- There was not sufficient oversight of the recording of serious incidents and we were not assured that lessons learnt were being rigorously identified and shared with all staff, including bank and agency staff. This was an issue that was identified as an area of concern in previous inspections.
- Only three out of the six planned clinical governance meetings had taken place over the past six months. This meant that clinical governance meetings were not fully embedded, and we could not be assured that lessons were being learnt.

Requires improvement

# Child and adolescent mental health wards

- Compliance with mandatory training had improved since the last inspection and the overall rate was 83% for Cherry Oak and 75% for Woodlands.
- Supervision and appraisal rates had improved since the last inspection. There was now a 100% appraisal rate for staff.
- Staff demonstrated clear understanding of safeguarding and Mental Health Act procedures and incorporated ongoing Mental Capacity Assessment and Gillick competence within their clinical practice.

**Leadership**

- Staff knew who the senior managers were on site and confirmed that the senior management team visited the wards regularly and spoke with patients and staff during these visits.
- Sickness absence rates for permanent staff for the period between 1st October 2017 and 30th September 2018 were 30% for Cherry Oak and 56% for Woodlands.
- Staff knew the provider's whistleblowing policy and said that they were confident to raise concerns without the fear of reprisals. We saw that staff asked questions and raised concerns during shift handover and staff meetings. There were no bullying and harassment cases reported to be under investigation at the time of the inspection.
- Staff cited cohesive, strong team working and peer support as factors in enabling them to provide care and treatment to patients.
- Staff told us they felt supported by managers and they mostly felt their concerns were listened to, however they did express frustration with the staffing situation, and the high turnover of staff, which not been satisfactorily resolved despite being a difficulty for some time.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure they deploy sufficient numbers of staff to ensure that they can meet people's care and treatment needs.
- The provider must ensure that patient observations are carried out safely and recorded appropriately.
- The provider must ensure the timely documentation of serious incidents and demonstrate evidence of communication to staff and patients of lessons learnt from incidents and complaints.
- The provider must ensure that locum doctors providing out of hours cover have further appropriate training and support to enable them to feel confident in managing challenging patients and reviewing risk
- The provider must improve documentation of managing violence and aggression incidents by ensuring the correct date is on the form, full details are given, body maps are completed, and the forms are counter-signed by a qualified member of staff.

### Action the provider SHOULD take to improve

- The provider should ensure that ligature risk assessments are easy to use.
- The provider should ensure that medicines are clearly labelled with open and expiry dates.
- The provider should ensure that care plans are individualised and all patients are offered a copy of their care plan.
- The provider should ensure all staff, including locum staff, have training in managing violence and aggression.

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 |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• The provider did not ensure that observations were carried out safely and recorded appropriately.<br>• The provider did not fully complete documentation of managing violence and aggression incidents. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• **The provider did not have sufficient systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.**<br>• **The provider had not demonstrated evidence of communication to staff and patients of lessons learnt from incidents and complaints.** |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>• The provider did not ensure that locum doctors providing out of hours cover had the appropriate training and knowledge to provide clinical expertise when reviewing patient clinical risk. |

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 |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>• The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards). |