Ellingham Hospital

Quality Report

Ellingham Hospital
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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

Overall summary

Ratings are not given for this type of inspection:

The Care Quality Commission carried out a focussed inspection of Ellingham Hospital on 23 and 24 January 2018.

In April 2017, a new ward opened, Redwood ward, offering a service to adults of working age. This is a different service to their other core business. We inspected to establish if the hospital was able to meet the needs of all patients safely.

We identified a number of concerns that required the urgent attention of senior managers. Specifically we issued a warning notice against Regulation 17 Good governance, 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:

- There was a failure to ensure systems and processes were established and operated effectively across all wards. Governance arrangements for frontline staff were not robust. The hospital did not ensure there were adequate reporting, audit and learning from incidents.
- We identified areas of clinical practice, where greater management oversight and leadership was required. On Redwood ward, staff failed to report incidents in line with the provider's policy. There was a process in place to report and investigate incidents on the CAMH wards and the hospital was unable to explain why Redwood did not work within this system. This demonstrated a lack of effective governance arrangements and management oversight.
- Individual patient risk assessments were not updated after incidents on Redwood ward and not all risks were identified within the care plans. Managers did not ensure there was an effective system of clinical audit across all the wards. For example, we saw evidence of poor care plans, staff not checking the emergency bags, which were not all stocked appropriately, and there were no ligature risk assessments in place on Redwood ward. This had a potential impact on the safe care and treatment of patients.
- Each ward had one registered nurse. The wards were busy and the nurse could not carry out all necessary tasks effectively. This level of staffing met the provider's own policy but may not meet patient needs, or enable staff to effectively document care, nor supported staff to take breaks away from the ward.

Summary of findings

- Mandatory training compliance was poor. Some training attendance figures were lower than 50% and as low as 33%. The provider held two sets of training data for safeguarding courses with completion of safeguarding children training ranging from 33-60% and safeguarding adults training ranging between 41-46%.
- The ward environment was unclean without an effective system in place to maintain cleanliness.

However:

- We observed that staff handled challenging situations with professionalism. Staff used verbal de-escalation with use of restraint techniques as a last resort during the inspection.
- Staff treated patients with dignity, care and respect and were familiar with each patient's care and support needs and preferences. Staff demonstrated the provider's values in their care and approach towards the patients.
- The teams felt well supported by their teams and senior managers.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units		This was an unannounced focussed inspection. We do not rate this type of inspection.
Child and adolescent mental health wards		This was an unannounced focussed inspection. We do not rate this type of inspection.

Summary of findings

Contents

Summary of this inspection

Background to Ellingham Hospital

Ellingham hospital has the capacity to care for up to a total of 34 patients. Two wards accommodate patients aged from 12 to 18 years, and one ward is 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 mixed sex specialist 10 bedded low secure inpatient ward for patients aged from 12 to18 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 mixed sex specialist general 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 had 14 beds available for use, with 11 occupied at the time of the inspection. Some patients were detained under the Mental Health Act whilst others were informal.

The Registered Manager is Alain Sockalingum.

At the last inspection in January 2017 Redwood Ward was not open and the service only provided care for CAMH patients. Actions we recommended the hospital should address following this inspection were:

- The provider should ensure that Cherry Oak ward is refurbished.
- The provider should ensure work continues in a specific and timely way to reduce the number of ligature points in the ward areas.
- The provider should ensure that adequate signage is in place to notify patients and visitors of the use of CCTV.
- The provider should continue to review and update their environmental risk assessment.
- The provider should ensure that all medical equipment is calibrated annually.
- The provider should ensure that parents are communicated with in a timely manner.
- The provider should review the provision of activities at weekends.

We found that the provider had addressed two of the identified concerns. The CCTV signage was in place across the site and in ward areas, and medical equipment was calibrated annually.

However, the other concerns remained outstanding; inspectors escalated these concerns to the provider during the inspection.

Our inspection team

Team leader: Jane Crolley - Inspector.

The inspection team consisted of two CQC inspectors and one CQC inspection manager.

Summary of this inspection

Why we carried out this inspection

Ellingham Hospital opened a new Adult Acute Mental Health Ward in April 2017. This is a different service to the Children and Adolescent Mental Health wards that are provided. We carried out this inspection to ensure the hospital was able to meet the needs of these two patient groups safely.

How we carried out this inspection

This was an unannounced focussed inspection.

To fully understand the experience of people who use services, we concentrated our inspection on the following domains:

- Is it safe?
- Is it caring?
- Is it well-led?

During the inspection, the inspection team:

- Visited the wards, checked the quality of the environment of all three wards and observed how staff were caring for patients
- spoke with the two ward managers
- met with nine patients who used the service
- spoke with 19 staff including doctors, nurses, and healthcare assistants.
- interviewed the registered manager
- reviewed 10 care and treatment records of patients
- observed six episodes of care
- spoke with one family member or carer
- attended two shift handover meetings, one safeguarding meeting with the Police and two multi-disciplinary ward round meetings
- reviewed a range of policies, procedures and other documents relating to the running of the service
- attended one morning meeting
- Visited the ward clinic rooms and examined 22 medication cards.

What people who use the service say

We spoke with 11 patients during this unannounced inspection.

One patient was looking forward to going on supported community leave with staff and their family member or carer. This offered them an opportunity to go clothes shopping and have a meal out. One patient spoke about their music preferences, and plans for spending time with their grandparents who were due to visit.

One patient discussed their care and support needs during their multi-disciplinary ward review meeting, and had the opportunity to make suggestions about their activities and seek clinical agreement to dye their hair.

One patient, with support from staff, spoke about their feelings having moved from Cherry Oak ward to Woodlands ward, and the level of progress made.

Two patients spoke about their medication, care and treatment needs whilst interacting with one of the qualified nurse when receiving their medication.

One family member or carer spoke positively about the quality of care and support provided at Ellingham Hospital. However they identified that communication by the ward varied dependent on which staff members were on shift.

Three patients said they felt supported by staff and listened to by them.

Three patients said they were unable to lock their bedroom doors and would feel better if they could.

Two patients said the ward bathrooms and kitchen were dirty and their bedrooms were only cleaned once per week.

Summary of this inspection

Two patients said they had leave cancelled or shortened due to staff issues and also said they had not been given a care plan or had a discussion about it.

Two patients said that they saw the doctor often and that staff always responded to their needs as soon as they could.

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?

Ratings are not given for this type of inspection.

We found the following areas that the provider needed to improve:

- Redwood ward did not have an effective system for reporting incidents. This meant that staff did not record incidents on an incident form nor any subsequent learning shared.
- Staff had not updated risk assessments on Redwood, based on clinical incidents that had happened.
- Staff did not always document patient observation levels in care plans or clinical records on Redwood. Staff did not discuss observation levels during staff handover on the CAMH wards.
- All wards had blind spots affecting staff ability to monitor patient movement around the ward. Closed circuit television was in place, but primarily used to review incidents and not routinely monitored by staff.
- Ward areas contained ligature points. There was an audit document in place for Cherry Oak and Woodland wards, which identified ligature points. However, these documents did not link to clinical risks for individual patients. The provider did not complete environmental risk assessments. There was nothing in place for Redwood.
- We saw evidence of restraint and rapid tranquilisation used on each of the wards. The provider did not have an effective system in place to report on the number of restraints and rapid tranquilisation administration on Redwood.
- Staff did not consistently check the contents of emergency grab bags on each ward. Staff were not sure of the frequency of checks. Some equipment was missing. For example, on Woodlands, there were no airways in either the green or the red emergency bag.
- There were gaps in medication management practices and procedures, for example, monitoring fridge temperatures, disposal of medication and completion of internal quality audits. Staff had not ensured each medication card had a photograph attached to reduce risk of administration error.
- The provider had a high vacancy rate. There were efforts on an ongoing basis to recruit to these posts. The provider confirmed gaps in staffing were filled by bank and agency staff.
- The provider had a staffing matrix which was designed to inform the level of staff required per shift. The ward skill mix (as per their policy) meant that there was one registered nurse per shift per ward.Inspectors observed multiple incidents

occurring, requiring the attention of the sole registered nurse on shift. This placed pressure on the registered nurse, and resulted in members of the multi-disciplinary team offering additional support. The nurse was unable to be everywhere managing all these different demands. We raised concerns with the provider that one registered nurse on shift struggled to meet the needs of all the patients in a safe manner.

- All wards were visibly unclean. Cherry Oak ward was in need of refurbishment. Staff on all wards were unable to provide cleaning records. This did not comply with infection control guidelines.
- Housekeeping staff did not have a process to account for all items on the trolley, and did not prevent the trolley being left unattended in patient areas.
- There was inconsistent completion and recording of ward security checks, including counting cutlery and environmental checks on Cherry Oak Ward.
- Due to deep scratches, the viewing panels in the seclusion room on Cherry Oak ward did not offer staff clear lines of sight for monitoring patient safety.
- Compliance with mandatory training across the hospital site was low. The provider held two sets of training data for safeguarding courses with completion of safeguarding children training ranging from 33-60% and safeguarding adults training ranging between 41-46%. Mental Health Act training completion was 57%, Mental Capacity Act training was 57% and Deprivation of Liberty Safeguards training was 66%. Enhanced observation training compliance was 57%. There was no plan to address this.
- Cherry Oak ward did not comply with Department of Health guidance on the elimination of mixed sex accommodation in hospitals, and Woodlands ward did not have designated male and female lounges. Although Redwood did not comply at the time of inspection this was due to the extensive refurbishment programme of this ward.
- Some ward staff did not have access to all of the keys relevant to meet the needs of their job role.
- Radio batteries were not all charged to ensure safety. This meant that the radios did not always work.

However:

- On Redwood, the environmental blind spots were partly due to on-going work that was underway to improve the ward environment.
- All registered nurses had undergone immediate life support training (ILS).

Summary of this inspection

- During the weekends, there was an additional senior registered nurse on duty during the day to provide additional support to ward based staff.
- We found that 98% of staff had received training in the management and prevention of aggression.
- Staff recognised the importance of working to least restrictive practice and linked use of blanket restrictions to individualised patient risks.
- We observed that staff handled challenging situations with professionalism. Staff used verbal de-escalation with use of restraint techniques as a last resort during the inspection.
- Staff spoke highly of the support offered by the consultant psychiatrists during the day and out of hours.

Are services caring?

Ratings are not given for this type of inspection.

We found the following areas of good practice:

- Staff treated patients with dignity, care and respect and were familiar with each patient's care and support needs and preferences.
- Staff expressed passion for their role and viewed their involvement in patient's treatment and care as paramount.
- In the CAMH wards, patients completed discussion request forms prior to the multi-disciplinary ward review meetings. Staff discussed the content and provided a written response for each patient.
- Independent advocates visited the wards each week and offered support with aspects of patient's care including Mental Health Act tribunals and making complaints.
- Staff supported patients to maintain and form relationships with family and friends where appropriate and to develop support networks to aid discharge back into the community.
- Some patients on the CAMH wards wrote lists of their likes, dislikes and preferences to enable staff to offer the patients support when their mental health deteriorated.
- For relatives who had a long journey there was accommodation available for them to book and stay overnight.

However:

- Care plans did not demonstrate patient involvement and did not consistently evidence if these had been offered to patients.
- Care plans were not holistic.

Are services well-led?

Ratings are not given for this type of inspection.

Summary of this inspection

We found the following areas that the provider needed to improve:

- There was a failure to ensure systems and processes were established and operated effectively across all wards. The hospital had failed to evaluate and improve their practice.
- We identified areas of clinical practice, where greater management oversight and leadership was required. For example, the process regarding reporting of incidents and the learning of lessons was inadequate and required immediate attention, specifically relating to Redwood. There was a process in place to report and investigate incidents on the CAMH wards and the hospital was unable to explain why Redwood did not work within this system. This demonstrated a lack of effective governance arrangements and management oversight.
- There was a lack of clinical governance across the hospital. For example, mandatory training compliance was poor, staff did not receive regular supervision and 42% of the staff had not had an appraisal in the last 12 months.
- The provider did not evaluate and improve their practice by means of effective audit and governance systems. The ward manager of Redwood ward and the registered manager confirmed during their respective interviews that there was no system to collate information about incidents, and therefore there was no review of themes and trends, with a view to improving practice.
- Some policies were out of date, but still in use by staff. These included the safe and therapeutic management of violence and aggression and care of patients in seclusion and longer-term segregation.
- The provider had not ensured that the skills and numbers of staff on the ward met the assessed needs of patients. This could adversely affect the safety of patients.
- The hospital did not have a risk register.

However:

- Staff demonstrated the provider's values in their care and approach towards the patients.
- The teams felt well supported by their teams and senior managers.
- Staff demonstrated clear understanding of safeguarding and Mental Health Act procedures, and incorporated ongoing Mental Capacity Assessment and Gillick competence within their clinical practice.
- There were no bullying and harassment or whistleblowing cases reported to be under investigation at the time of the inspection.

Summary of this inspection

- Staff morale was good on Redwood and Woodlands ward.

Detailed findings from this inspection

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

Safe	
Caring	
Well-led	

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

Safe and clean environment

- Redwood ward layout had several blind spots affecting staff ability to monitor patient movement around the ward. This was partly due to on-going work that was underway to improve the environment. There was no plan to mitigate the risk. The ward manager, registered manager and staff were unaware of any environmental risk assessment in place. The Consultant Psychiatrist, however, showed us a detailed environmental risk assessment completed in response to the building work taking place. Staff completed this in November 17 specifically for the patient group admitted at the time. The team were not aware of its existence and did not have clear plans of mitigating current risks.
- The ward had numerous 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. The ward manager confirmed that there was no ligature risk assessment completed for the ward. Inspectors immediately escalated this concern to the registered manager.
- The ward provided care for both male and female patients. Redwood did not comply with accommodation for eliminating mixed sex Department of Health guidance. However, the inspection took place during a period of refurbishment. There was no separate lounge for female patients. Male patients had to walk past female bedrooms. Staff told us that there would be separate corridors and lounges upon completion of this work. Staff positioned themselves in the corridor, however we saw occasions when staff were elsewhere.
- We saw an incident had happened during inspection where a male patient was disinhibited in his behaviour. The consultant psychiatrist responded and addressed the concern. The provider did not report the incident to safeguarding and the CQC until this was requested.
- Staff did not check the medical emergency response bag regularly. Staff were confused about what the expectation was regarding frequency of checks. This was of concern as the staff had no assurance of the correct content and that items were in date. We escalated this concern to the senior managers on site.
- Kitchen fridges were not clean, and staff did not monitor and record the temperature. Food within the fridge was not labelled correctly.
- The ward area was visibly dirty. The windows were very dirty, carpets not hoovered and dust on surfaces. The ward manager was unable to show us records to demonstrate regular cleaning took place. We raised this concern immediately with the provider.
- Infection control training completion rates across the hospital site was 57% and we saw that staff did not follow the provider's safety and hygiene policy and wore nail varnish or gel nails.
- Staff told us the housekeeping team cleaned communal areas daily and completed specified tasks as requested by ward staff. Housekeepers cleaned bedrooms on a weekly basis. Cleaning of the kitchen and laundry rooms were due to be completed by night staff. The provider was unable to provide evidence of cleaning records to inspectors.
- There were insufficient numbers of ward keys to allocate to staff.
- Safety alarms were not offered to inspectors.

Safe staffing

- The provider informed us that Redwood had a high vacancy rate. There were five registered nurse vacancies. There were efforts on an ongoing basis to recruit to these posts. The provider confirmed gaps in staffing were filled by bank and agency staff.
- The provider had a staffing matrix which was designed to inform the level of staff required per shift. The ward skill mix (as per their policy) meant that there was one registered nurse for up to 12 patients. Inspectors observed multiple incidents occurring, requiring the attention of the sole registered nurse on shift. At the same time this nurse was required to attend the ward

round. This placed pressure on the registered nurse, and resulted in members of the multi-disciplinary team offering additional support. The nurse was unable to be everywhere managing all these different demands. We raised concerns with the provider that one registered nurse on shift struggled to meet the needs of all the patients. There were support workers in communal areas.

- As there was only one registered nurse on duty, it was difficult for the nurse to take a break off the ward. Staff told us that at times, either they did not have a break or a nurse on another ward held keys. There was a risk that at times the ward would then have no registered nurse available on the ward.
- The ward manager was not counted in the staffing numbers and was able to provide the ward with some support in relation to breaks if available. This did not ensure that cover was provided at all times.
- Information regarding staffing levels for the day was not displayed for patients to see.
- The ward manager confirmed that there was autonomy in increasing support worker staffing linked with the need for enhanced 1:1 observations. However, we saw that at times, staff had to cancel patient leave off the ward in response to ward acuity and unavailability of staff to support it. Staff made every effort to rearrange leave for another day or time. Patients expressed frustration at this although understood the reasons.
- We found that 56 out of 57 staff were trained to carry out physical interventions.
- A consultant psychiatrist was available on the ward Monday to Friday who provided clinical leadership to the team. There was an on-call system to ensure there was medical cover outside of these hours.
- Immediate life support training compliance was 100% with all registered nurses having been trained to this standard. This was particularly important due to the rural location, as ambulances may not be able to respond within eight minutes.
- Mandatory training compliance was poor. Figures were not broken down per ward and overall figures are shown in the summary of this report.

Assessing and managing risk to patients and staff

- Redwood did not have a seclusion room. There were two documented incidents of seclusion in the last six months. On one occasion it was necessary to use the CAMH facility. The provider reported both incidents to the CQC.
- We saw evidence that staff used restraint and rapid tranquilisation. The provider did not have an effective system in place to report on the number of restraints and rapid tranquilisation administration.
- The ward manager advised that staff did not document incidents on the risk assessment nor on an incident form. We were told the incident would be recorded only in the contemporaneous notes. We saw some evidence of a limited amount of completion of incident forms. These forms were kept in a drawer and not used for purposes of review and learning of lessons. We raised this concern immediately with the provider.
- We did not see evidence of prone restraints, however, incidents were not documented and monitored. This meant that we could not know if prone restraints took place.
- Risk assessments took place within 24 hours of admission in three of the five records reviewed. Staff completed one risk assessment five days after admission and a fifth record showed staff completed it nine days after admission. Staff did not complete risk assessments in a timely manner in all instances.
- The risk care plans that were present contained minimal information on how individual risks were to be managed. The provider did not audit the quality of risk assessments and care plans.
- The provider's observation policy was not followed by staff. For example; where enhanced observations were required, information in the care plan relating to this was lacking. It was unclear what the level of observations prescribed were, or the reason for them along with what other plans were in place to reduce identified risks.
- Where there was controlled access to the garden, staff implemented this system to reduce risks and if a patient wished to access the garden outside of this time, they were able to do so.
- Staff used rapid tranquilisation only after other interventions had not been successful. When staff did use it, there was evidence of attempts to carry out physical observations.
- There was appropriate signage on the ward advising informal patients of their right to leave the ward.

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

- Staff spoken with knew about the provider's safeguarding policy and procedures and knew how to escalate any concerns. Safeguarding incidents were not broken down per ward and overall figures are in the summary of this report. Staff took action with one incident that occurred at the time of the inspection visit. Appropriate reporting of this incident to CQC did not take place.
- An external pharmacist was responsible for the audit of medication management. The registered nurses were responsible for complying with the medication management policy. The ward manager relied on the weekly audit that the pharmacist carried out. There were no internal checks carried out by the provider. This meant that staff, for up to a week, might not correct a concern such as a drug error.
- Children's visits were facilitated within the building but away from the ward. There was also accommodation for families, as the provider acknowledged the rural location made travelling to visits difficult. There was a policy relating to this to ensure its' safe use.

Track record on safety

- Since the ward opened in April 2017, there have been eight serious incidents documented and investigated in accordance with the provider's policy. Three of these incidents related to patients absconding from the ward over the fence. The provider had taken action to mitigate this by increasing the height of the fence and increasing staff presence in the garden.

Reporting incidents and learning from when things go wrong

- There was not an effective system of reporting incidents. Staff did not report incidents consistently. There was no system in place to learn from incidents. There was no evidence of how the lessons learned from incidents were shared with staff. The inspection team raised this concern immediately with the senior managers for their urgent attention.
- Staff demonstrated an open and transparent approach with patients when things had gone wrong.
- Staff confirmed they received debriefing sessions following significant incidents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person. We saw evidence of the provider responding to complaints in an open and transparent manner. Inspectors reviewed examples of responses sent to complainants by the provider. The responses were comprehensive and in the spirit of the duty of candour, whilst this was not explicitly mentioned.

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

Kindness, dignity, respect and support.

- We observed staff to be kind, caring, knowledgeable and responsive to patients on the ward.
- Feedback from patients was positive about staff attitude and said that staff were caring and understanding but too busy.
- We saw that staff knocked on all patients' door prior to entering and were respectful towards them.

The involvement of people in the care they receive

- There was a welcome pack, which a patient said was 'packed with information'.
- We saw evidence of ward reviews that involved patients in the planning of their care and being involved in decisions.
- The care plans did not demonstrate patient involvement in five out of the six care plans we looked at and held limited information about the patient.
- Patients were able to access independent advocacy and there was information on display explaining how.
- Staff supported patients to maintain and form relationships with family and friends where appropriate.
- Patients could access spiritual and religious support, with visits arranged on site or attendance at services in the community.
- Patients met with family and other professionals involved in their care in designated meeting rooms off the wards.
- For relatives who had a long journey there was accommodation available for them to book and stay overnight.

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

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

Vision and values

- The organisations vison and values were displayed within the building. We saw that staff demonstrated the provider's values in their care and approach towards the patients.
- Staff knew who the senior managers on site were, and confirmed that they visited the ward regularly.

Good governance

- There was a lack of clinical governance on the ward. For example, mandatory training compliance was poor, staff did not receive regular supervision and 58% of the staff had not been appraised in the last 12 months.
- The provider did not evaluate and improve their practice by means of effective audit and governance systems. The ward manager of Redwood ward and the registered manager confirmed during their respective interviews that there was no system to collate information about incidents, and therefore there was no review of themes and trends, with a view to improving practice.
- The provider failed in its duty to provide a clean ward environment and had not carried out audits to ensure that cleanliness standards were met.
- We saw two staff arrive late for the morning handover and managers did not address this at the time.
- The provider had not ensured that the skills and numbers of staff on the ward met the acuity of patients. For example, each registered nurse was working hard throughout their shift, unable to take regular breaks and was managing multiple tasks and pressures. This could adversely affect the safety of patients.
- There were numerous incidents occurring alongside the normal ward activity, including ward reviews. Staff from the CAMH wards provided support. Other non-ward based clinicians were also available to help. The manager was unable to assure us that this was sustainable outside of office hours.
- The ward manager confirmed there were no audits carried out by ward staff. For example, this meant that the poor quality of care plans and risk assessments were not reviewed and there was no formal system to address shortfalls.
- There was no process in place regarding the reporting of incidents and the learning of lessons from these. This meant that improvements could not be made to the safe delivery of care and treatment to patients on the ward. This was brought to the attention of senior managers.
- The ward manager told us that there was no ward specific risk register.

Leadership, morale and staff engagement

- Sickness absence rates across the hospital were 3.5% and staff turnover for the same period was 25%.
- There were no reported cases of bullying and harassment and staff knew how to raise a concern and use the whistle blowing process.
- Staff spoken with were positive about their job and felt supported to do their work. Morale was reported to be high.
- Staff worked together as a team and was supportive of each other and the patients.

Child and adolescent mental health wards

Safe	
Caring	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Cherry Oak and Woodlands wards both contained blind spots affecting the ease of monitoring patients in all ward areas. Closed circuit television was in place, but primarily used to review incidents and not routinely monitored by staff. There was signage in place to inform patients and visitors of its use. Some ward areas contained mirrors to partially mitigate risks. Ligature cutters were available on each ward, and some staff wore cutters on their belts when working with patients assessed to be at high risk of securing ligatures.
- Ward based areas contained ligature points. There was an audit document in place for each ward, which identified ligature points (fittings to which patients intent on self-injury might tie something to harm themselves). These documents were lengthy and hand written.These did not enable agency and new staff to become familiar with the ward environment, and the associated risks to patients in a timely manner.
- Some of these risk assessments were illegible and did not link to clinical risks for individual patients. Reduction and management of ligature risks was an area of concern identified in the 2017 inspection report.
- Woodlands ward did not fully comply with Department of Health guidance on the management of mixed sex accommodation. For example, bedrooms with en-suite bathrooms and corridor areas separate for male and female patients were compliant. However, the ward did not have designated male and female lounges.
- Cherry Oak ward did not comply with Department of Health guidance on the elimination of mixed sex accommodation in hospitals. This was because the bedroom corridor with a separate lounge, usually assigned to male patients, was in use as for a patient in long-term segregation. The remaining ward area accommodated both male and female patients. The layout of the ward resulted in female patients needing to pass male bedrooms to access the communal lounge and dining area.
- Both wards had a clinic room. On Cherry Oak ward, we found that the medication fridge was unlocked. The fridge temperature indicated readings between 12 and 26 degrees, yet medication continued to be stored in this fridge. Inspectors escalated this matter to the ward manager as the efficacy of the medication needed checking. Staff had not sealed the sharps bin on Cherry Oak despite a member of staff signing it as locked. Staff addressed both these concerns immediately.
- Some patients on Woodlands ward required administration of controlled drugs. The staffing complement of one qualified nurse per shift meant a second nurse from another ward or the ward manager needed to attend to countersign for the medication when administered. The keys for the clinic room and controlled drugs cupboard were on the same bunch, this posed a potential risk of two staff not accessing the controlled drugs. Inspectors brought to the attention of the controlled drugs officer on site.
- The clinic room fridge thermometer on Woodlands ward read 25.2 degrees on the day of the inspection. Staff reported the thermometer gave unreliable readings but no alternative arrangements were in place to address this. We informed the ward manager immediately.
- Registered nursing staff told us that they disposed of medication by putting it in the sharps bin, as there was no designated drug disposal bin. The sharps bin on Woodlands ward was not dated to indicate when opened for use. Two bottles of medication on Woodlands ward did not have stickers to indicate when the medication was opened, three bottles had stickers to indicate when the medication was opened but they did not indicate when the medication was due to expire.
- Both wards had medical emergency response bags. The bag on Cherry Oak ward was unzipped, and did not contain a checklist or record of completion of content checks. The content of the bag on Woodlands ward did not match the checklist, with some items kept in a

separate cupboard. There was a red emergency bag on Woodlands ward; this did not contain equipment for maintaining a patient's airway. Registered nurses were unaware that the emergency bags did not contain all items needed in an emergency.

- The provider had a programme in place for maintenance of medical equipment, with records to indicate annual calibration. This addressed an area of concern identified in the 2017 inspection report.
- Cherry Oak ward had the only seclusion suite in the hospital. This consisted of a de-escalation room with weighted seating, and the main seclusion room with a separate toilet, sink and shower area. The suite was clean, and contained a mattress that staff moved in and out of the seclusion room as required. To observe a patient in the seclusion room, staff stood in the de-escalation room with the doors closed and observed the patient through viewing panels in the door and a window overlooking the bathroom area. All viewing panels were heavily scratched impacting on observation and lines of sight, it was unclear what patients used to make these marks. Convex mirrors were in the main seclusion area and bathroom, but the scratched viewing panels affected line of sight. The condition of the seclusion room viewing panels had been identified by a Mental Health Act Review visit completed in May 2017.
- Some ward areas were dirty and in need of refurbishment on Cherry Oak ward. This was an area of concern identified in the 2017 inspection report. The carpets throughout the ward were in need of hygiene cleans, particularly on the corridor in use for a patient in long-term segregation. Staff reported incidents of bodily fluids making contact with soft furnishings, including carpets.
- The therapy kitchen and dining room on Woodlands ward were both dirty, with debris on the floors and in rubbish bins. An incident, two weeks before the inspection, resulted in temporary closure while the maintenance team mended the door and the dirt was from this repair work.
- The housekeeping team did not hold a list of items contained on the cleaning trolley to know that all items remained on the trolley at the end of a shift. The housekeepers told inspectors they could account for all items by their position on the trolley, but this did not offer a robust risk management approach.
- Kitchen fridges on both wards contained patient's food, with name labels attached, but nothing to indicate when they opened the food and therefore when items needed to be disposed of. Inspectors could not find records of fridge temperature monitoring on either ward.
- Infection control training completion rates across the hospital site was 57%. This did not meet the providers own training completion target. Registered nurses washed their hands prior to administration of medication. Many staff were observed not to be dressed bare below the elbow, or adhere to the provider's safety and hygiene policy in relation to wearing raised rings and jewellery that presented a potential risk for being grabbed or a choking hazard to the wearer.
- Staff reported that housekeeping team cleaned communal areas daily and specified tasks as identified by ward staff. Housekeeping cleaned bedrooms on a weekly basis. Cleaning of the kitchen, laundry and seclusion rooms were for completion by night staff. The provider was unable to provide evidence of completed cleaning records.
- The provider did not complete environmental risk assessments. This was an area of concern identified in the 2017 inspection report.
- Patients had access to nurse call buttons, and approached staff if needing assistance.

Safe staffing

- Cherry Oak ward reported to have 12 substantive staff consisting of two qualified nurses, three senior support workers and seven support workers. The ward had two qualified nurse and two support worker vacancies. The provider confirmed bank and agency staff covered gaps in staffing levels due to sickness or absence for this ward.
- Woodlands ward reported to have 12 substantive staff consisting of three qualified nurses, four senior support workers and five support workers. The ward had one ward manager, two qualified nurse and four support worker vacancies. The provider confirmed bank and agency staff covered gaps in staffing levels due to sickness or absence for this ward.
- Staffing levels for day and night staff on Woodlands ward was one qualified nurse and three support workers with a twilight shift worker. Staffing levels on Cherry Oak ward one qualified nurse and eight support workers

during the day, one qualified nurse and six support workers overnight and a twilight shift worker. The ward manager worked across the two wards and not counted in staffing numbers.
- During the weekends, there was an additional senior registered nurse on duty during the day to provide additional support to ward based staff.
- The provider had a work force plan in place for both wards, and was actively recruiting to vacancies. There was one ward manager to cover both wards, but a newly appointed ward manager was due to start in post.
- Staff reported concerns to CQC relating to staffing levels, and only having one registered nurse per shift. Staff told inspectors having a second registered nurse on each shift would improve safety on the wards, and be in line with the quality network for child and adolescent mental health staffing guidelines.
- Inspectors observed multiple incidents occurring on both wards, requiring the attention of the sole registered nurse on shift. This placed pressure on the nurse, and resulted in members of the multi-disciplinary team offering additional support. Staff raised concerns at the potential risk of making mistakes, for example, with medication administration. The ward manager worked across the two wards to offer the qualified nurses breaks, cover for sickness and counter signing controlled drug medication.
- Due to the complexity of patients on both wards, consistency of staffing levels and skill mix were essential to the safe running of the ward. Inspectors observed times where support staff responded to emergencies on other wards, reducing staffing levels on their allocated wards. This raised a concern in relation to having sufficient staff on shift to be able to cover breaks, and to carry out physical intervention when required.
- Staff rotas indicated a consistent use of agency rather than core staff to cover night shifts. From a review of serious incidents on Cherry Oak ward, the provider identified correlation between episodes of patient on patient assaults in the evenings and use of agency staff. In response to these findings, the provider introduced a twilight shift, with an additional support worker on the ward. The provider planned to review the effectiveness of this action.
- Staff told us, where possible that the provider used regular bank staff, as they were familiar with the ward environment and patients.
- Inspectors identified that not all registered nurses were registered learning disability or mental health nurses, instead registered as a general nurse. Registered nurses from the other wards supported new admissions to the ward and scrutiny of Mental Health Act paperwork.
- Registered nurses reported to offer regular one to one sessions with patients. Inspectors observed that all staff interacted with patients, offered support, and talk time throughout the shifts. While completing tasks such as administering medication, registered nurses used this opportunity to discuss other aspects of the patient's care and support needs.
- For January 2018 on Cherry Oak ward, staff recorded seven episodes of leave cancellation. One record indicated leave was rescheduled leave due to staffing shortages; the remaining six indicated the patient declined to go on leave.
- Staff supported patients with their individual activity timetable. This consisted of one to one and group activities alongside their own education sessions. No concerns were raised in relation to levels of activity provision at weekends.
- Staff spoke highly of the support offered by the consultant psychiatrists during the day and out of hours. The provider used locum consultant psychiatrists as required to cover leave and sickness.
- Registered nurse training compliance across the hospital site for intermediate life support training was 100%, however basic life support training including use of the defibrillator for all ward based staff was 62% compliance and safe handling of medication training for registered nursing staff was 37% both below the providers own compliance target. Mandatory training compliance was poor. Figures were not broken down per ward and overall figures are shown in the summary of this report.

Assessing and managing risk to patients and staff

- We examined a sample of seclusion records. Registered nursing staff audited the paperwork and signed off the seclusion packs against a log sheet before archiving the paperwork. The log sheets recorded the time seclusion commenced and ceased, when staff informed the responsible clinician of the seclusion and when the first medical review was completed. Two entries on the log sheet did not indicate what time staff informed the responsible clinician, only when the medical review was

completed. It was therefore unclear for these two episodes of seclusion if completion of the initial medical review was in line with the Mental Health Act Code of Practice timescales.

- On Cherry Oak ward in the three months prior to the inspection there had been 200 episodes of restraint, one resulting in use of prone restraint and one patient nursed in long term segregation. No concerns in relation to the use of rapid tranquilisation were identified from the five medication cards examined. There was a segregation care plan linked to the provider's policy.
- On Woodlands ward for the three months prior to the inspection there had been 19 episodes of restraint, none resulting in use of prone restraint and no episodes of long term segregation reported. No concerns in relation to the use of rapid tranquilisation were identified from the seven medication cards examined.
- Staff demonstrated a clear understanding of safeguarding practices and recognising types of abuse, and had links with the onsite social worker to report safeguarding concerns to the local authority. We attended a safeguarding meeting with the police during the inspection where the team discussed issues thoroughly.
- Staff confirmed that unless there were exceptional circumstances, they assessed each patient face to face before accepting a new admission. This ensured that they met the hospital's admission criteria, by taking into account the complexity and support needs of the existing patients.
- Staff collected risk information before admission and reviewed this regularly at multi-disciplinary meetings and during shift handovers. Staff used formulation tools to identify risks, formulate action plans and identify severity of patient needs.
- From the five patient care and treatment records examined with staff, two did not contain preadmission risk assessment documents, and two records did not contain updated risk assessments after incidents occurred.
- Some policies were out of date, but still in use by staff. For example, this included the safe and therapeutic management of violence and aggression and care of patients in seclusion and longer-term segregation.
- Woodlands ward accepted informal patients; with information on the rights of informal patients displayed in ward areas and by exit doors. There were no informal patients admitted at the time of the inspection.
- Staff recognised the importance of working to least restrictive practice and linked use of blanket restrictions to individualised patient risks.
- Examples of patients on increased observation levels and requiring physical intervention were seen during the inspection. The staff handled challenging situations with professionalism. Staff used verbal de-escalation with use of restraint techniques as a last resort during the inspection.
- There was a high level of 1:1 enhanced observations on Cherry Oak ward. This required a member of staff to be with the patient at all times. The provider policy 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 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.
- Inspectors identified that the observation level information displayed on the office wipe board for Cherry Oak ward was incorrect, staff amended this immediately. Staff did not discuss or review observation levels during the shift handover meeting inspectors attended.
- From the 12 medication cards examined, one had an incomplete date for the administration of a dose of PRN medication (medication given as needed). Consent to treatment forms, second opinion doctor assessments and Mental Capacity Act assessments were stored with the medication cards where applicable.
- There were gaps in medication management practices and procedures, for example, monitoring fridge temperatures, disposal of medication and completion of internal quality audits. Staff on Woodlands ward had not ensured each medication card had a photograph attached to reduce risk of administration error.
- The provider had a pharmacy contract in place. Part of the contract included completion of medication audits. Staff relied solely on the findings from these external audits and did not complete local checks.
- Staff on both days of the inspection did not all have radios with charged batteries at the start of their shift, and there were insufficient numbers of ward keys to allocate to staff.
- Security keys for the ward were in the nursing office rather than assigned to a designated member of staff. Staff had keys for the contraband and restricted items

storage facilities on both wards. Woodlands ward did not keep a count of cutlery and crockery in a recording book, but staff reported to count items in and out to account for them at the start and end of each meal.
- On Cherry Oak ward, staff completed security checks and documented this in a security book along with other risk items. Inspectors examined the security book and identified gaps in recording; inspectors escalated this to the support worker assigned to security for the shift.
- Safety alarms were not offered to inspectors.
- Patients on Woodlands ward accessed mobile phones without SIM cards. Access to technology was individually risk assessed.
- Access to bedrooms during the day was risk assessed on an individual basis for both wards. Staff encouraged patients to attend school and participate in education and activities during the day to reduce risk of isolation.

Track record on safety

- Cherry Oak had reported 317 incidents in the three months prior to the inspection and Woodlands ward had reported 62 incidents. The nature of these incidents included episodes of physical aggression, self-harming and patient on patient abuse.

Reporting incidents and learning from when things go wrong

- Staff were familiar with the provider's incident reporting procedures. The ward manager reviewed incidents and completed investigations where applicable. Staff recorded incidents on a paper form, and followed the providers policy regarding the reporting of incidents.
- Staff discussed incidents during shift handovers and at the multi-disciplinary ward review meetings, with the information documented in patient's records.
- Staff confirmed they received debriefing sessions and support through supervision and meetings with the ward manager following incidents.
- Inspectors reviewed incident audits for the three months prior to the inspection for both wards. The provider collected this information from the paper incident forms completed by staff. The audit did not indicate areas of improvement or dissemination of lessons learnt to prevent reoccurrence.
- Staff gave examples of changes made to reduce and mitigate risks. These included introduction of the twilight shift to offer additional support after school hours, and designated staff carrying ligature cutters on their belts when working with patients assessed to be at high risk of securing ligatures.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Inspectors saw examples of feedback given to patients and their carers or family members. Staff provided written and verbal feedback information where appropriate, as part of the multi-disciplinary ward review meetings.

Are child and adolescent mental health wards caring?

Kindness, dignity, respect and support

- Staff treated patients with dignity, care and respect and were familiar with each patient's care and support needs and preferences.
- Staff expressed passion for their role and viewed their involvement in patient's treatment and care as paramount.

The involvement of people in the care they receive

- Staff told us they collected information on patient's likes and dislikes prior to admission. This information was used when personalising their bedroom. An example that staff used was making picture boards of television characters a patient liked to assist them to settle onto the new ward.
- There was a staff photograph board located on each ward to aid recognition and assist patients with getting to know core staff, but staff told us these needed to be updated.
- Patient records examined demonstrated variable levels of patient involvement in the development of their care plans. From the care plans examined, two did not record the patient's views, one demonstrated involvement from the patient, and one indicated the patient was unable to participate, as they were unwell at the time.

Child and adolescent mental health wards

- Four out of five care plans documented that the patient had a copy of their care plan. However, one indicated that the patient required support from staff to understand the information provided.
- Patients completed discussion request forms prior to the multi-disciplinary ward review meetings. Staff supported patients to complete the forms and the team discussed the content, providing a written response for each patient. Staff spent time after the review meeting explaining the outcomes, particularly if the patient was unable to attend.
- Independent advocates visited the wards each week and offered support with aspects of their care, including Mental Health Act tribunals and making complaints. On Cherry Oak ward, the advocate met with each patient individually, with support from staff and recorded the outcomes of their discussions.
- Woodlands ward did not hold regular community meetings. Minutes reviewed during the inspection indicated staff held the last meeting on 28 November 2017. It was therefore unclear what opportunities patients on Woodlands ward had to provide feedback and escalate concerns about the service. Those meeting minutes contained limited information and did not indicate how staff demonstrated to patients they had acted on feedback received.
- Staff supported patients to maintain and form relationships with family and friends where appropriate and to develop support networks to aid discharge back into the community.
- Patients could access spiritual and religious support, with visits arranged on site or attendance at services in the community.
- Some patients wrote lists of their likes, dislikes and preferences to enable staff to offer the patients support when their mental health deteriorated.
- We spoke with one family member or carer, who gave positive feedback about the quality of care and support provided at Ellingham Hospital. However, they told us that communication by the ward varied dependent on which staff members were on shift. This was an area of concern identified in the 2017 inspection report.

Are child and adolescent mental health wards well-led?

Vision and values

- 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.
- The senior management team visited the wards regularly and met with patients during these visits.

Good governance

- We identified areas of clinical practice, where greater management oversight and leadership was required. For example, ward security, management of staff breaks, infection control practice, the quality of community meeting minutes and the robustness of shift handovers.
- The provider was collating incident information on the CAMH wards with a view to improving practice.
- Whilst managers carried out regular quality walk arounds across the hospital, they had not identified concerns in relation to the hygiene and cleanliness standards on the wards.
- The quality and content of shift handover lacked detail around patient risks, care and support needs. Inspectors attended the morning shift handover meeting for Cherry Oak ward, two staff arrived late and one staff member did not arrive for the meeting. It was unclear if they received a separate shift handover.
- Inspectors observed a session run by the ward consultant and the management of violence and aggression trainer, to review the care and support needs of one patient. This was an interactive session, and designed to offer staff a forum for raising concerns and seeking advice.
- The provider had not ensured that the skills and numbers of staff on the ward met the assessed needs of patients. This could adversely affect the safety of patients. For example, staff raised concerns that there was one registered nurse on the ward for every shift. Each registered nurse was working hard throughout their shift, unable to take regular breaks and was managing multiple tasks and pressures. This could adversely affect the care and treatment given to patients.
- Compliance with mandatory training across the hospital site was below the provider's own target. The provider collected mandatory training figures for the whole hospital site, and was unable to break the data down to a ward level.

Child and adolescent mental health wards

- Annual appraisal rates for the hospital site were 58% and inspectors identified gaps in recorded clinical and managerial staff supervision.
- Registered nurses had supernumerary days to enable them to complete audits of seclusion paperwork and quality of staff recording on electronic patient records. These days were happening on an ad hoc basis, but provided the registered nurses with the time to complete these additional tasks.
- The ward manager confirmed they would be responsible for addressing staff performance issues as identified. No staff were reported to be suspended or under investigation in relation to their practice.
- The provider did not have a risk register in place.
- A newly appointed administrator supported staff with tasks such as scanning documents onto the electronic recording system. Inspectors observed that staff spent the majority of their time with patients positioned in ward areas rather than in the nursing office.
- Staff demonstrated clear understanding of safeguarding and Mental Health Act procedures, and incorporated ongoing Mental Capacity Assessment and Gillick competence within their clinical practice. Evidence of multi-disciplinary decision making linked to these clinical procedures was observed during ward review meetings.
- Some policies were out of date, but still in use by staff. These included the safe and therapeutic management of violence and aggression and care of patients in seclusion and longer- term segregation.

Leadership, morale and staff engagement

- Sickness absence rates across the hospital were 3.5%.
- 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 multi-disciplinary ward review meetings.
- There were no bullying and harassment cases reported to be under investigation at the time of the inspection.
- Staff told us that their morale was good on Woodlands ward. On Cherry Oak ward staff reported low morale. Staff attributed this to the acuity of patients admitted at the time of the inspection.
- Staff spoke passionately about their jobs whilst acknowledging the challenges they faced. Staff cited cohesive, strong team working and peer support as factors in enabling them to provide care and treatment to patients.
- Staff identified areas of personal and professional development opportunities, including acting up into more senior roles on the ward. Whilst temporary, this offered staff the opportunity to try new roles and responsibilities with the option to return to their previous role.

Commitment to quality improvement and innovation

- Both wards were part of the Quality Network for Inpatient Child and Adolescent Mental Health services (QNIC) accreditation. This was due for review in March 2018.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that a governance system is in place to capture all the identified concerns.
- The provider must ensure there is a system and process on Redwood ward for reporting and recording incidents and learning.
- The provider must have an effective system in place on Redwood ward to report on the number of restraints and episodes of rapid tranquilisation administration.
- The provider must demonstrate improved evidence of communication to staff and patients of lessons learnt from incidents and audits on all wards.
- The provider must ensure there are sufficient skilled and experienced registered nursing and support staff on each shift to meet the needs of the patient group and to enable staff to take their breaks during each shift.
- The provider must implement environmental improvements to mitigate blind spots.
- The provider must complete, review and update environmental audits.
- The provider must complete, review and update ligature risk audits and linked these to patient's clinical risks.
- The provider must improve medication management practices and procedures.
- The provider must ensure emergency grab bags have the appropriate content and are checked by suitably trained staff.
- The provider must ensure all ward areas are kept clean in adherence to infection control practices.
- The provider must ensure that staff adhere to infection prevention control procedures, and the provider's dress code.
- The provider must ensure compliance with the Department of Health guidance on the elimination of mixed sex accommodation.
- The provider must immediately replace the seclusion room viewing panels to ensure clear lines of sight.
- The provider must ensure staff are complaint with their mandatory training.
- The provider must ensure food items stored in fridges are stored correctly to prevent the risk of infection. Fridge temperature must be recorded daily and action taken if concerns are identified.
- The provider must ensure staff have a way to account for all items on the cleaning trolley, and prevent this being left unattended in patient areas.
- The provider must ensure consistent completion and recording of ward security checks on Cherry Oak ward.
- The provider must ensure ward based staff have access to keys relevant to meet the needs of their job role and charged radio batteries at the start of each shift to ensure safety.
- The provider must ensure enhanced observation levels are documented clearly in care plans and are reviewed daily, ensuring that this information is reflected in patient notes and during handover meetings.
- The provider must ensure that care plans demonstrate patient involvement and if a copy has been offered to the patient.
- The provider must ensure staff receive regular clinical and managerial supervision and annual appraisals.
- The provider must ensure all policies and procedures are up to date for staff to access.

Action the provider SHOULD take to improve

The provider should ensure that staff update carers and family members in relation to the care and treatment of the patient where appropriate.

- The provider should ensure that ward based staff have access to keys relevant to meet the needs of their job role and charged radio batteries at the start of each shift ensuring safety.
- The provider should ensure all wards hold regular community meetings, and complete detailed minutes to reflect points discussed and actions taken to address concerns.
- The provider should ensure that staff update the ward office wipe boards with the correct observation levels for each patient.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had not ensured that care plans demonstrated patient involvement and if a copy had been offered to the patient. This was a breach of regulation 9.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not implemented environmental changes to mitigate blind spots. • The provider had not improved medication management practices and procedures including monitoring fridge temperatures, disposal of medication, completion of internal quality audits, ensured each medication card had photographs attached to reduce risk of administration error. • The provider had not discussed patient observations in all handovers. There was limited information in care records and care plans. There was no evidence of daily review of enhanced observations. • The provider had not ensured that all staff adhered to infection prevention control procedures, and the provider's dress code. • The provider had not ensured fridge temperatures were routinely monitored and recorded. • The provider had not ensured food items stored in fridges were labelled with when the date items were opened and when they were due to expire.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that staff had a way to account for all items on the trolley, and prevent the trolley being left unattended in patient areas.
- The provider had not ensured consistent completion and recording of ward security checks on Cherry Oak.
- The provider had not ensured that the correct observation levels for each patient were documented, and that this information was reflected in patient notes and during handover meetings.
- The provider had not ensured compliance with the Department of Health guidance on the elimination of mixed sex accommodation.

This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured policies and procedures were up to date for staff to access. This was a breach of regulation 17.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not developed an effective system to report incidents and capture this information to inform clinical practice. • The provider had not developed a governance system to capture all the identified concerns. • The provider had not demonstrated evidence of communication to staff and patients of lessons learnt from incidents and audits. • The provider had not completed, reviewed and updated environmental audits. • The provider had not completed, reviewed and updated ligature risk audits and linked these to patient's clinical risks. • The provider had not ensured there was an effective system in place on Redwood ward to report on the number of restraints and episodes of rapid tranquilisation administration. • The provider had not ensured emergency grab bags had assigned content check lists, that staff completed regular checks of content and replaced items after each use, with clear designation of roles and responsibility set out for who and when this should be completed. • The provider had not ensured all ward areas were clean with adherence to infection control practices. • The provider had not immediately replaced the seclusion room viewing panels to ensure clear lines of sight.

This section is primarily information for the provider

Enforcement actions

- The provider had not ensured staff received regular clinical and managerial supervision and annual appraisals and did not have an effective system for monitoring this.

This was a breach of Regulation 17