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	Not sufficient evidence to rate
Are services safe?	Not sufficient evidence to rate
Are services caring?	Not sufficient evidence to rate
Are services well-led?	Not sufficient evidence to rate

Overall summary

Staff had failed to ensure that patients were restrained using appropriate techniques. Four patients we spoke with told us that they had been harmed whilst being restrained by staff using more than minimal force.

Although the service had enough nursing and support staff to keep patient's safe we found out of four staff on shift two to three staff on shift that were blocked booked agency staff. Patients had their escorted leave or activities postponed and rescheduled when the ward was short of staff or if staff were required to carry out enhanced observations of patients.

Ward managers determined the level of staffing numbers on the ward but did not book staff to work on the ward. The person responsible for booking staff was an administrator and not a clinical member of staff or someone in a management position. The administrator was not qualified to determine what skills and competencies staff should have in order to appropriately and safely meet the needs of individual patients, thereby exposing patients to the risk of harm.

Staff had failed to carry out all nursing observations in line with the patients care plan to maintain their safety. We were concerned that on some occasions staff were carrying out observations longer than what the hospital policy stipulates. The lack of observations or length of time staff carried out observations could have potentially impacted on patient safety.

Summary of findings

Staff did not always administer medication in accordance with the patients' prescribed medication. We found on one occasion that staff had administered eight milligrams of diazepam in a 24-hour period when the patient had only been prescribed six milligrams of diazepam in a 24-hour period.

Three of the patients we spoke with reported that they could not get access to staff as staff were always busy and that they had not been involved in their treatment plans and had not seen their care plans. Two patients reported that day staff were respectful and caring but night staff were rude and had at times been very forceful and aggressive.

Managers failed to provide a consistent and stable leadership team over a prolonged period of time. At the time of the inspection, a interim hospital director had been appointed for three months as the provider had not been able to recruit a permanent member of staff into this position. We found a lack of leadership due to this there was no clarity on what manager roles were within the service.

Governance meetings were often cancelled and did not contain accurate up to date information for a comprehensive meeting to take place and a robust plan of actions to be set to improve the service. We viewed the hospital risk register. The register was not up to date and did not reflect current issues.

Managers did not investigate incidents thoroughly. The services system was for incidents to be reviewed and closed by the Director of Clinical Services. Of the 14 records we looked at, only two had been reviewed and closed by the Director of Clinical Services, despite the incidents suggesting that patients could be exposed to the risk of harm.

There was no clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Managers did not ensure that staff had access to regular clinical supervision. We reviewed six clinical supervision records and found no evidence that showed staff's competence to care for the patients on Redwood 1 ward was being assessed. The records also did not reflect that managers have gained assurances that staff were being appropriately supervised and their clinical competencies being monitored to ensure they were protecting patients from harm or exposure to the risk of harm.

Managers did not deal with poor staff performance when needed. Managers were fearful that if they challenged staff's performance then staff would put in a grievance against them, therefore they took no action. Managers reported that the ward staff had an unhealthy culture and there were frictions within the team.

However,

Two patients told us that they had been involved in their care planning and understood their treatment plans. Additionally, three patients we spoke with reported that staff responded well to them when they were struggling and that they tried to support them.

One family we met during the inspection said they felt involved in their family members care and that staff were friendly and helpful. The had regular contact with the doctor and had been involved in the planning of care for their family member.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Ward areas were clean, well maintained, well furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were visibly clean. Staff followed infection control policy, including handwashing.

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident. Staff knew the individual risks for each patient. When patients were admitted to the ward the doctors carried out a comprehensive assessment of the patients mental and physical health.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Patients records showed that staff were reporting safeguarding incidents when necessary.

Four staff we spoke with felt valued, respected and supported by ward staff, including the ward manager.

Summary of findings

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Not sufficient evidence to rate

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure 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 4 to 18 years, and two 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. The provider for Ellingham Hospital is Partnerships in Care Limited.

Ellingham hospital has four wards, Cherry Oak and Woodlands are Tier 4 children and adolescent wards, (CAMHS) and Redwood 1 and Redwood 2 are wards 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 12 to 18 years with conditions such as complex neuro-developmental disorder, learning disability, attention deficit hyperactivity disorders and mental health problems. At the time of inspection there were four patients on the ward 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 four patients on the ward. Patients could be detained under the Mental Health Act or informal.

Following a comprehensive inspection in January 2019, the CQC issued a warning notice against one regulation of the Health and Social Care Act. This was issued in January 2019 against Regulation 18 HSCA (RA) Regulations 2014 staffing:

- 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).

The CQC also issued a requirement notice against three regulations of the Health and Social Care Act: These were issued in January 2019 against Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment, Regulation 17 HSCA (RA) Regulations 2014 Good governance and Regulation 18 HSCA (RA) Regulations 2014 Staffing:

- The provider must ensure that observations were carried out safely and recorded appropriately.
- The provider must ensure that staff fully complete documentation of managing violence and aggression incidents.
- The provider must 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.
- The provider must 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 had the appropriate training and knowledge to provide clinical expertise when reviewing patient clinical risk.

Following a focussed inspection on 26th June 2019, the requirements of the warning notice were met. We found improvements in incident recording and training for locum doctors. A further requirement notice was issued against Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- The provider did not ensure that body maps were completed, or recorded as appropriate, after every incident.
- The provider did not ensure that staff always followed the Priory observation policy and procedures to ensure that observations sheets were being correctly signed and counter-signed.
- The provider did not ensure that staff labelled opened bottles of medicine with the date of opening.

The Care Quality Commission carried out an urgent and focussed, unannounced inspection of Ellingham Hospital on 4,5 and 10 September 2019. We found significant and immediate concerns that required immediate action on the two child and adolescent wards. We worked closely

Summary of this inspection

with the Clinical Commissioning Group, the Local Authority, NHS England and the Priory Group senior management team to ensure that immediate concerns for the health and wellbeing of the young people were acted on. We began enforcement proceedings against Ellingham Hospital to close both of the child and adolescent mental health wards. This process is still on going.

The Care Quality Commission has a duty under Section 3 of the HSCA to consider the immediate safety and welfare of the young people at the hospital. We looked at this throughout our unannounced inspections.

Our inspection team

The team that inspected the service was comprised of two CQC inspectors a CQC assistant inspector and a CQC inspection manager.

Why we carried out this inspection

We carried out a focussed inspection of Redwood 1 ward, acute wards for adults of working age due to the concerns found and urgent enforcement action that had taken place against the child and adolescent mental wards.

How we carried out this inspection

This was a focussed, unannounced inspection.

For the purpose of this inspection we asked the following questions:

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

During the inspection visit, the inspection team:

- visited Redwood 1 ward, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with the interim hospital director and managers for the ward;
- spoke with five other staff members; nurses, healthcare assistants and the occupational therapist;
- spoke with a family member;
- reviewed seven care and treatment records of patients;
- carried out a specific check of the medication management and clinic room;
- looked at a range of policies, procedures and other documents relating to the running of the service

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?

Not sufficient evidence to rate

Staff had failed to ensure that patients were restrained using appropriate techniques. Four patients we spoke with told us that had been harmed whilst being restrained by staff using more than minimal force.

Although the service had enough nursing and support staff to keep patient's safe we found out of four staff on shift two to three staff on shift that were blocked booked agency staff.

An administrator and not a clinical member of staff or someone in a management position responsible for booking staff on duty. The administrator was not qualified to determine what skills and competencies staff should have in order to appropriately and safely meet the needs of individual patients, thereby exposing patients to the risk of harm.

Patients had their escorted leave or activities postponed and rescheduled when the ward was short of staff or if staff were required to carried out enhanced observations of patients.

Staff had failed to carry out all nursing observations in line with the patients care plan to maintain their safety. We were concerned that on some occasions staff were carrying out observations longer than what the hospital policy stipulates. The lack of observations or length of time staff carried out observations could have potentially impacted on patient safety.

Staff did not always administer medication in accordance with the patients prescribed medication. We found one occasion where staff had administered eight milligrams of diazepam in a 24-hour period when the patient had only been prescribed six milligrams of diazepam in a 24-hour period.

However,

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Ward areas were clean, well maintained, well furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand washing.

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident. Staff knew the

Summary of this inspection

individual risks for each patient. When patients were admitted to the ward the doctors carried out a comprehensive assessment of the patient's mental and physical health. This included, if the patient consented to blood tests and electrocardiograms.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Patients records showed that staff were reporting safeguarding incidents when necessary.

Are services caring?

Not sufficient evidence to rate

Patients reported that they had been hurt or staff had been aggressive towards them during restraint. Three of the patients we spoke with reported that they could not get access to staff as staff were always busy. Two patients reported that day staff were respectful and caring but night staff were rude and had at times been very forceful and aggressive.

Three out of five patients told us that they had not been involved in their treatment plans and had not seen their care plans.

We saw no evidence that staff had acted to address the feedback that patients had given.

However,

Two patients told us that they had been involved in their care planning and understood their treatment plans. Additionally, three patients we spoke with reported that staff responded well to them when they were struggling and that they tried to support them.

One family we met during the inspection said they felt involved in their family members care and that staff were friendly and helpful. They had regular contact with the doctor and had been involved in the planning of care for their family member.

Are services well-led?

Not sufficient evidence to rate

Managers failed to provide a consistent and stable leadership team over a prolonged period of time. At the time of the inspection, an interim hospital director had been appointed for three months as the provider had not been able to recruit a permanent member of staff into this position.

We found a lack of leadership due to this there was no clarity on what manager roles were within the service. Managers reported that the ward staff had an unhealthy culture and there were frictions within the team.

Summary of this inspection

There was no clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Governance meetings were often cancelled and did not contain accurate up to date information for a comprehensive meeting to take place and a robust plan of actions to be set to improve the service.

We viewed the hospital risk register. The register was not up to date and did not reflect current issues. There were still risks identified on the plan dating back to December 2016. Whilst these had been updated in June 2019 it was unclear whether these reflected current or ongoing risks.

Managers had not investigated incidents thoroughly. The services system was for incidents to be reviewed and closed by the Director of Clinical Services. Of the 14 records we looked at, only two had been reviewed and closed by the Director of Clinical Services, despite the incidents suggesting that patients could be exposed to the risk of harm.

Managers did not ensure that staff had access to regular clinical supervision. We reviewed six clinical supervision records and found no evidence that showed staffs competence to care for the patients on Redwood 1 ward was being assessed. The records also did not reflect that managers have gained assurances that staff were being appropriately supervised and their clinical competencies being monitored to ensure they were protecting patients from harm or exposure to the risk of harm.

Managers did not deal with poor staff performance when needed. Managers were fearful that if they challenged staff's performance then staff would put in a grievance against them, therefore they took no action.

However,

Four staff we spoke with felt valued, respected and supported by ward staff, including the ward manager.

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

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards.

The ward complied with guidance and there were no mixed sex accommodation breaches.

Managers completed ligature audits. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Ward areas were clean, well maintained, well furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including hand washing.

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

Safe staffing

Nursing staff

Although the service had enough nursing and support staff to keep patient's safe we found out of four staff on shift two to three staff on shift that were blocked booked agency staff.

We reviewed the number of staff deployed on Redwood1 ward. On one occasion records showed that on 17 September 2019 only two staff were on shift, despite the number of patients' resident in the ward and one patient required one to one nursing support. On the 14 September 2019 all staff were agency staff.

Staff reported that patients had one to one sessions with their named nurse but these weren't as regular as they could be. Two out of five patients we spoke with reported that they had one to ones with staff. Three other patients told us that they didn't have them.

Patients had their escorted leave or activities postponed and rescheduled when the ward was short of staff or if staff were required to carried out enhanced observations of patients.

The service had the required number of unqualified nursing staff. Managers were actively recruiting to qualified nursing posts but with limited success.

Ward managers determined the level of staffing numbers on the ward and preferred to book agency staff that were familiar to the service, although this was not always possible. We looked at your systems for ensuring that staff working on the ward had the necessary skills and competence to meet the needs of the patients. We found that the person responsible for booking staff was an administrator and not a clinical member of staff or someone in a management position. The administrator was not qualified to determine what skills and competencies staff should have in order to appropriately and safely meet the needs of individual patients, thereby exposing patients to the risk of harm.

Managers did not assure that staff were being appropriately supervised and their clinical competencies being monitored to ensure they were protecting patients from harm or exposure to the risk of harm. Four out of the five members of nursing staff reported that they were receiving clinical supervision. However, in the records in staff files there was nothing in their supervision records that showed their competence to care for the patients on Redwood 1 ward was being assessed.

Managers could adjust staffing levels according to the needs of the patient. However, this increased the numbers of agency staff on the ward.

Due to the high use of agency staff, managers ensured that all agency staff were trained and provided with supervision by the providers. Prior to starting their shift agency staff were given time to read risk assessments and care plans and familiarise themselves with the layout of the ward.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The responsible medical officer was always on site. There were two doctors who worked part time but fulfilled a full medical post.

Mandatory training

The mandatory training programme covered a variety of topics and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. We reviewed 12 training records which showed that four out of 12 staff had completed 100% of training. The remaining eight staff had completed 75% or more of the training.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident. We reviewed seven risk assessments, which highlighted historical and current individual risk of patients. Only one assessment had not been updated after an incident.

When patients were admitted to the ward the doctors carried out a comprehensive assessment of the patients mental and physical health. This included, if the patient consented to blood tests and electrocardiograms.

Management of patient risk

Staff knew the individual risks for each patient. In one patient's risk assessment staff had highlighted a significant date when the patient's risk levels would increase and had plans to support the patient during this time.

If required staff would use increased nursing observations to support patients when they were displaying high levels of risk. We reviewed the records of these observations and found that they had been mostly completed. We found two occasions on 30 September when staff had not completed the observations records for two patients. Staff had not recorded observation for the first patient from 1230hrs to 0430hrs. The second patients record had not been completed between 1030hrs to 1230hrs and 1630hrs to 2030hrs. Staff we spoke with reported that when incidents occurred increased nursing observations were not carried out as they have to respond to the incident. We reviewed the incident log for this date and found that no incidents had been recorded. The lack of observations could have potentially impacted on patient safety.

We were concerned that on some occasions staff were carrying out observations longer than what the hospital policy stipulates. From 24 September 2019 to 30 September 2019 we found 15 occasions where staff had been on nursing observations for longer than two hours. The longest time a member of staff had been on observations was six hours.

Staff gained patients consent prior to pat down searching patients when they returned from leave. Staff had access to an electronic wand to search patients, if required. However, patients still managed to get a lighter on the ward.

Restraint

This service had 14 incidences of restraint between 01 July 2019 and 30 September 2019. Four of these incidents occurred on Redwood Two Ward which was closed prior to this inspection. Of the 10 that took place on Redwood ward none resulted in prone restraint and involved six different patients.

We spoke to five patients during our inspection. Four of them told us in confidence they had been harmed whilst being restrained by staff using more than minimal force. One patient told us they do not feel safe on the ward and that a member of staff had pushed them. Another said that night staff were very forceful and aggressive. The third said they were restrained with an inappropriate amount of force. During the restraint they told us they were not resisting staff intervention, but the member of staff restraining them had forced pressure through their hands and that another member of staff had grabbed them on the jaw and shouted at them. The fourth told us that staff had been heavy handed with them during a restraint. We informed senior management of these incidents and they took action.

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

We reviewed records to determine if they accurately recorded every incident of restraint and the level of force used. We have reviewed 14 incident forms from the 01 July 2019. The only incidents that were reported related to restraint of the fourth patient referred to above. There was no record of incidents of restraint relating to the other three. We were concerned that not all incidents of restraint had not been recorded and therefore the patients had not been safeguarded against inappropriate use of restraint and force.

However, the incident reports that were present and patient case notes did demonstrate that staff had attempted to avoid using restraint by using de-escalation techniques.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Patients records showed that staff were reporting safeguarding incidents when necessary.

Staff training records showed that staff had kept up-to-date with their safeguarding training.

The services safeguarding log highlighted four safeguarding incidents taken place in Redwood 1 ward from 01 July 2019 to 30 September 2019. The log highlighted what immediate actions had been taken by staff to minimise the risk of repeated incidents.

Medicines management

Staff followed systems and processes when safely prescribing, recording and storing medicines. However, we found that staff, on one occasion had administered eight milligrams of diazepam in a 24 hours period when the patient had only been prescribed six milligrams of diazepam in a 24 hour period. Staff were unaware that this error had taken place until we raised it with them during the inspection. Therefore, no action had been taken to ensure the patients safety or address the issues with the nurse that administered the medication.

Staff reviewed patient's medicines regularly and provided specific advice to patients.

The pharmacist completed regular audits and any actions identified were addressed. The pharmacist was available to give advice to doctors and nursing staff, including during out of office hours.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. All patients had a national early warning score chart attached to the medication chart which staff had completed regularly.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew what incidents to report and how to report them.

Staff discussed incidents that had taken place on the ward during handovers of shifts.

On occasions managers debriefed and supported staff after any serious incident. However, we found no evidence that debriefing was available to patients or that they were offered support after incidents or exposure to the risk of harm and whether they had been given the opportunity to raise any concerns.

Staff did not meet regularly as a team or with managers to discuss the feedback from incidents or lesson learnt.

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

Kindness, privacy, dignity, respect, compassion and support

During the inspection we noted that staff were discreet, respectful, and responsive when caring for patients. However, patients reported that they had been hurt or staff had been aggressive towards them during restraint.

Three of the patients we spoke with reported that they could not get access to staff as staff were always busy.

Two patients reported that day staff were respectful and caring but night staff were rude and had at times been very forceful and aggressive.

Staff supported patients to understand and manage their own care treatment or condition.

Staff did not always understand and respected the individual needs of each patient. Although, three patients with spoke with reported that staff responded well to them when they were struggling and that they tried to support them.

Involvement of patients

Three patients told us that they had not been involved in their treatment plans and had not seen their care plans. However, two patients told us that they had been involved in their care planning and understood their treatment plans.

We found no evidence that staff involved patients in decisions about the service, when appropriate.

We saw no evidence that staff had acted to address the feedback that patients had given. Patients could give feedback on the service and their treatment via community meetings. We saw in the minutes of these meetings that patients raised similar issues without any plans of action to resolve the issues.

Involvement of families and carers

We spoke with one family member during the inspection. They felt involved in their care and that staff were friendly and helpful. The had regular contact with the doctor and had been involved in the planning of care for their family member.

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

Leadership

Managers failed to provide a consistent and stable leadership team over a prolonged period of time. At the time of the inspection, an interim hospital director had been appointed for three months as the provider had not been able to recruit a permanent member of staff into this position.

We found a lack of leadership due to this there was no clarity on what each specific manager roles were within the service. In the last few years the service had had eight different hospital directors. All of which had their own vision of how the service should be run and had set up different systems to manage the service. As they had now all left the service there was only one senior manager that had access to the all the necessary information. Due to this the manager was not able to perform their current role effectively and had become an administrator of information.

Culture

Four staff we spoke with felt valued, respected and supported by ward staff, including the ward manager. However, they did not find that senior managers were as supportive.

Staff felt able to raise concerns without fear of retribution and three staff were confident about the whistleblowing process. One member of staff reported that they would raise concerns but questioned who would listen to them if they did.

Managers did not deal with poor staff performance when needed. Managers were fearful that if they challenged staff's performance then staff would put in a grievance against them, therefore the took no action. The interim hospital director had plans in place to support managers to address this.

Whilst the ward team reported that they felt they worked well together, managers reported that the ward staff had an unhealthy culture and there were frictions within the team.

Governance

There was no clear framework of what must be discussed at a ward, team or hospital level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

We reviewed the last governance meetings minutes held 2nd August 2019 (although this was the July governance meeting). This evidence that the meeting did not discuss all the items on the agenda or have the correct up to date information for a comprehensive meeting to take place and a robust plan of actions to be set to improve the service.

The meeting minutes stated there were no safeguarding incidents on Redwood 1 ward. However, the safeguarding log clearly shows that there was a patient on patient assault on 07 July 2019. There was no record of any actions taken or decisions in regard to this matter and the incident

and complaints section of the minutes were blank. We were concerned that managers did not have oversight of all relevant or correct information in order to maintain the safety of patients.

In addition to this, the minutes stated that quality objectives, the risk register and audits and research were recorded as to be discussed at the next meeting. We were informed during the inspection that the governance meeting was often cancelled. We looked to see if you had any staff meetings and ward manager meetings as alternative ways to discuss with and feed back to staff about the risk to patients in the months when governance meetings were cancelled. We found that the ward managers meetings minutes dated 01, 08 and 15 August 2019, did not have the lessons learnt from incidents or risk issues as an agenda item and there is no evidence that these topics were discussed. The staff meetings minutes dated 24 May 2019 and 19 June did not discuss risks or lessons learnt nor was it on the agenda. We were concerned that the service did not have any alternative systems in place and that there was no oversight of how information in relation to the service was being shared with staff.

Management of risk, issues and performance

We viewed the hospital risk register. The register was not up to date and did not reflect current issues, such the recent closure of child and adolescent ward and the impending closure of the remaining child and adolescent ward or the vacancy for a substantive registered manager. There were still risks identified on the plan dating back to December 2016 and whilst these had been updated in June 2019 it was unclear whether these reflected current or ongoing risks.

Managers did not investigate incidents thoroughly. The services system was for incidents to be reviewed and closed by the Director of Clinical Services. Of the 14 records we looked at, only two had been reviewed and closed by the Director of Clinical Services, despite the incidents suggesting that patients could be exposed to the risk of harm.

Managers did not ensure that staff had access to regular clinical supervision. We reviewed six clinical supervision records and found no evidence that showed staffs competence to care for the patients on Redwood 1 ward was being assessed. The records also did not reflect that managers have gained assurances that staff were being appropriately supervised and their clinical competencies being monitored to ensure they were protecting patients from harm or exposure to the risk of harm.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The registered provider must not admit any patients to the inpatient Acute wards for adults of working age inpatient at Ellingham Hospital without prior written agreement of the Care Quality Commission.
- The provider must ensure that steps will be taken so that patients are restrained using the minimum amount of force necessary.
- The provider must ensure all incidents of restraint and the level of force used is accurately recorded so that there is a clear record of the number of times restraint is used with patients and the level of force involved.
- The provider must ensure that all incidents reported are reviewed by the Clinical Director or a member of staff in an equivalent role and appropriate action taken and recorded.
- The provider must ensure that topics and information intended to be discussed at governance meetings are fully considered and that any learning or action required is shared with appropriate members of staff even when the meetings are cancelled.
- The provider must ensure that the patients on Redwood ward are cared for by staff with the relevant competence and skills.

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	S12 Notice of Decision to impose a condition of registration Notice of Decision served under Section 31 of the Health and Social Care Act 2008. 1. With immediate effect, the Registered Provider must not admit any patients to the inpatient Acute wards for adults of working age inpatient at Ellingham Hospital without prior written agreement of the Care Quality Commission. 2. By 11 October 2019, the Registered Provider must send to the Care Quality Commission with a written action plan completion dates for the following: The steps that will be taken to ensure that patients are restrained using the minimum amount of force necessary The steps taken to ensure that all incidents of restraint and the level of force used is accurately recorded so that there is a clear record of the number of times restraint is used with patients and the level of force involved The steps taken to ensure that all incidents reported are reviewed by the Clinical Director or a member of staff in an equivalent role and appropriate action taken and recorded The steps taken to ensure that topics and information intended to be discussed at governance meetings are fully considered and that any learning or action required is shared with appropriate members of staff even when the meetings are cancelled The steps taken to ensure that the patients on Redwood ward are cared for by staff with the relevant competence and skills.

This section is primarily information for the provider

Enforcement actions

3. By 18 October 2019 an every 7 days after that, the Registered Provider must send to the Care Quality Commission an updated action plan in writing progress made and information and the improvements that still need to be made.