Partnerships in Care Limited

St John's House

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Overall summary

We found;-

- An audit of ligature points had been carried out . There were potential ligature points in bathroom and bedroom observed on Walsham and Waveney wards relating to taps and doors. The provider had rated these as low risk. Patients assessed as at risk of self harm or suicide had specific care plans to address this risk.
- The Patients' Council and three other patients reported feeling unsafe because of the number of incidents, patient on patient physical assaults and sexual harassment. The patients' council did not consider that the issues it raised were responded to by the hospital.
- Staff at St. John's House used physical restraint to control the behaviour of patients on 684 occasions in the six months leading up to the inspection visit. On 290 of these 684 occasions the patient was restrained in the prone (face-down) position. 56% of the prone restraints related to one patient. Staff told us that prone restraint was used as part of planned packages of care. An audit report dated 10 April 2015 showed that number of restraints were reducing each month during 2014.
- Department of Health guidance published in April 2014 is that planned or intentional prone restraint should not be used. The guidance also calls for providers to implement restrictive intervention reduction programmes. The managers of St. John's house had established such a programme.
- 98% ward staff had been trained in using positive behavioural support (PBS) to minimise and manage challenging behaviour. However, care plans did not consistently include the functional assessments of behaviour that underpin PBS. Also, staff did not use proactive strategies to reduce the likelihood of disturbed behaviour such as anticipating and meeting patients' needs.
- The dignity of patients was affected by the lack of seclusion furniture in two seclusion rooms.
- There was a lack of regard to the Mental Health Act Code of Practice in failing to record discussions relating to second opinion appointed doctors' reviews, and the prescribing of medication in relation to statutory treatment certificates.
- Performance information was collected and reported from "ward to board" which had been recently introduced. This information was not fully embedded in ward areas as staff were not able to say how the data informed decision making to drive improvement and inform ward objectives.
- Staff were trained in risk management and emergency care. Staff felt safe on the wards. Staff knew how to report incidents and safeguarding issues.
- National Institute for Health and Care Excellence (NICE) guidance was followed in relation to medication. Clinical audits were being undertaken, that showed positive results. The hospital had published research into interventions it was used such as mindfulness and positive behaviour support.
- The majority of patients said that they could talk to staff and were listened to. They received one to one sessions and felt supported by the clinical team.
- There was a care pathway that patients followed and co-ordinated discharges were organised.
- Most staff felt supported by senior managers. Healthcare support workers were and exception. This group of staff did not feel listened to. There was good team working, and staff received managerial supervision.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found **;-**

- The Patient's Council and three patients reported that they felt unsafe on the wards because of patient on patient physical assaults, patient bullying and patient on patient sexual harassment.
- Between 1 April and 30 September 2014 there were 179 episodes of seclusion, 55 instances of rapid tranquilisation. 110 instances of self harm reported. There were 72 incidents reported to the safeguarding team for investigation. There were 684 episodes of restraint of which 290 were in the prone position. 56% of prone restraints were carried out on one patient. We were concerned at the high level of restraints and prone restraints. The hospital were reviewing the prone restraints and putting care plans in place. The hospital provided an audit report dated 10 April 2015 which showed that the number of restraints and seclusions were falling per month from May 2014 onwards.
- Bure ward seclusion room did not have a communication system.
- Waveney seclusion room did not have any furniture, this was contrary to the MHA Code of Practice.
- A quite room on Walsham was occasionally used for seclusion contrary to the MHA Code of Practice.
- A qualified nurse was not present at all times in the communal areas overseeing the patients.

Ligature audits and risk assessments were undertaken. There were potential ligature points in bathroom and bedroom observed on Walsham and Waveney wards relating to taps and doors. The provider had rated these risks as low. Patients assessed as at risk of self harm or suicide have specific care plans to address this risk.

Staff were trained in risk management and emergency care. Staff felt safe on the wards. Staff knew how to report incidents and safeguarding issues. Ward to board reporting happened and the information was shared with ward managers and staff at staff meetings and handovers, However, this was not embedded in team objectives so that improvements could be made .

Are services effective?

We found that :-

Summary of findings

- Due regard to the Mental Health Act Code of Practice was not demonstrated because :-
  - Statutory consultees did not record their discussion with the second opinion appointed doctor (SOAD).
  - The responsible clinician did not record that the outcome of the SOAD visit had been discussed with the patient.
  - Patients were not provided with a copy of their section17 leave form.
  - One patient had been prescribed more medication than had been authorised on the treatment certificate.
  - Searches were being undertaken as a blanket approach without individual assessment..

Risk assessments, care and health plans were used to deliver care and treatment. National Institute for Health and Care Excellence (NICE) guidance was followed in relation to medication. The teams used Health of the Nation Outcome Scales- Secure (HoNOS-S), which is an outcome measure, which decides the progress of therapeutic intervention for individual patients. Historical Clinical Risk Management-20 which estimates a person's probability of violence was being used for individual patients. Clinical audits were being undertaken, that showed positive results. The hospital had published research into interventions it was used such as mindfulness and positive behaviour support.

Are services caring?

We found that :-

The majority of patients said that they could talk to staff and were listened to. They received one to one sessions and felt supported by the clinical team. We observed that staff were respectful and interacted positively with patients.There were Patients' Council and community meetings that took place regularly.

Are services responsive to people's needs?

We found that:-

- In the Patients' Council the same issues were raised many times by patients and were not well addressed by staff.
- The multi faith room was used for activities other than what it was meant for.
- There was not much easy read literature available to patients at a level they could understand.
- The hospital monitored the amount of activities offered and taken up between 17 November2014 to the 23 November 2014

Summary of findings

the number of planned meaningful activities offered on the wards was 2,576 of which 1,099 were not taken up. Audit results identified reasons for the lack of take up as patients not being interested or being unwell and due to cancellations.

- Not all patients knew how to complain or felt they were informed of the progress of investigations,

There were 76 complaints made in the previous 12 months of which 48 were upheld. Complaints were analysed and themes identified so that lessons could be learnt. The hospital clinical priority for 2014/15 was to develop and implement systems for lessons learnt. 87% of nursing staff had completed training in the handling of complaints.

There was a care pathway that patients followed and co-ordinated discharges were organised. Patients were able to go on home visits and there were family rooms available to facilitate visiting.

Are services well-led?

We found that **;-**

Most staff felt supported by senior managers. Healthcare support workers were and exception. This group of staff did not feel listened to. There was good team working, and staff received managerial supervision.

There were governance practices used to monitor performance. Ward managers had access to a range of performance indicators in the form of a dashboard. This required further work so that it informed ward objectives and ward action plans. The wards participated in the quality network for forensic mental health services; a peer review scheme run by the Royal College of Psychiatrists. This showed commitment to improve performance through the implementation of the recommendations.

Summary of findings

Summary of findings

What people who use the location say

- We spoke to 22 individual patients. The majority of patients reported that they were treated with respect and that staff were caring and good.
- The Patients' Council told us that the same issues were raised which were not dealt with. Issues that were raised related to staff shortages affecting activities, staff spending too much time in the office instead of with patients, agency staff not knowing the patients, their needs and background this sometimes made them feel unsafe. The Patients' Council told us that it was embarrassing when out in the community for the staff identity badges to be clearly visible and that the logo lanyards should be replaced. The hospital responded by stating backpacks would be used by staff in future. We observed that staff did not respond or give considered explanations to issues being raised during the patients' council meeting.
- A patient satisfaction survey was carried out in May 2014 which covered four hospitals .The results available were not specific to St John's although 35 out of 79 participants were from St John's. The results overall were largely positive.
- A carers and relatives survey was carried out by the provider in May 2014 across four of its learning disability service locations. The results were not specifically for St John's. The findings were largely positive; although visiting was highlighted as a difficulty due to distance, cost and transport. Not all respondents felt consulted and involved in Care Programme Approach (CPA) meetings. Not all had received information about rights as the nearest relative.

Areas for improvement

Action the provider MUST take to improve

- The hospital must review its use of restraint and continue to implement its restrictive intervention reduction plan to ensure that restraint is used only as a last resort.
- The hospital must ensure that it takes account of the Department of Health guidance that there should be no planned or intentional restraint in the prone (face-down) position.
- The hospital must monitor continuously its use of restraint and review all incidents of prone restraint.
- The hospital must ensure that, whenever appropriate, its care plans apply the principles of positive behavioural support and are underpinned by a functional assessment of behaviour..
- Risk management plans must be in place to manage ligature risks identified in audits. These should include taps in the patient corridor bathrooms and bedroom ensuite doors. These should also be reflected in patient risk plans on Waveney and Walsham ward.
- The hospital must demonstrate regard to the Mental Health Act Code of Practice by ensuring that;-
  - A communication system is in place in Bure ward seclusion room.
  - The seclusion room on Redgrave ward is furnished with regard to the Mental Health Act Code of Practice. Quiet rooms on Redgrave ward are not used to seclude people.
  - Blanket restrictions are reviewed; such as routine searches of patients returning from leave, access to bedrooms.
  - Medication is prescribed within the boundaries authorised on the treatment certificate.
  - Patients are provided with a copy of their section17 leave form.
  - Recordings are made by the responsible clinician of the discussion with the patient about the outcome of the SOAD visit.
  - Recordings are made by statutory consultees following their discussion with the second opinion appointed doctor (SOAD).

Action the provider SHOULD take to improve

- The hospital should increase the percentage of staff undertaking mandatory training in order to support the reduction of restraints, seclusions, and patient

incidents. The training should include de -esclastion techniques, breakaway training , management of behaviour and aggression, observations and medicines management.

- The hospital should undertake further work to ensure patients know how to complain and how they are kept informed of investigations.

Good practice

- A whole staff team away day occurred on each ward every three months. This gave staff the opportunity to discuss what went well and what needed to be better to ensure their practice was effective in meeting patients' needs.
- Patients in the learning disability services have won over 30 Koestler Art Awards over the last five years

St John's House

Detailed findings

Services we looked at:
Forensic inpatient/secure wards

Our inspection team

Our inspection team was led by:

Surrinder Kaur CQC Inspection Manager

The team included one specialist advisor who was a consultant psychologist in learning disabilities, one expert by experience supported by a support worker, three inspectors and two Mental Health Act reviewers.

Background to St John's House

St John's House services are part of Partnerships in Care (PiC) specialist learning disability services, located in the village of Palgrave in Norfolk.

It is a 49 bedded unit which provides medium and low secure services for men and women. The unit provides care and treatment to adults with learning disabilities who have a history of offending behaviour and other conditions including autistic spectrum disorders, Asperger's syndrome, personality disorders and mental illness. All patients are detained under the Mental Health Act. Patients' come from all parts of the United Kingdom.

The unit consists of four wards:-

- Walsham ward provides medium secure services for men and has 16 beds.
- Redgrave ward is a medium secure service for women and has 16 beds.
- Bure ward provides low secure services for women and has 11 beds.
- Waverney is an assessment and treatment ward for women and has six low secure beds.

St John's House has been inspected nine times since 2010. At the last inspection in July 2013 it was compliant against the five regulations that were inspected.

Mental Health Act monitoring visits have been carried out every year.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services' we always ask the following five questions of every service and provider:

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

Detailed findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the location and asked other organisations to share what they knew. We carried out an announced visit on the 24 November 2014. During the visit we held focus groups with a range of staff who worked within the service; such as nurses, doctors, therapists,and support workers. We talked with people who use services. We observed how people were being cared for and reviewed care and treatment records of people who use services. We wrote to carers to invite them to speak to us. However we received no responses.

We spoke to 33 staff and 22 patients. We viewed 13 case records and 10 medication records.

Is the service safe?

Our findings

Safe and clean ward environment

- Staff were able to observe all parts of the wards to protect patients' safety. Where blind spots had been identified, mirrors had been installed to reduce the risks.
- Audits of ligature risks were completed. Walsham ward had ligature risks such as taps in the patient corridor bathrooms, and bedroom ensuite doors. On Waveney ward the door and window hinges in the bedroom, lounge and bathroom area were ligature risks. The ligature risk assessment had identified these risks as low . Patients assessed as at risk of self harm or suicide had specific care plans to address this risk.
- Ward provision was for single sex accommodation.
- Emergency equipment and drugs were provided on each ward and ready to be used. Staff checked these daily. A defibrillator was provided on Walsham ward that was shared with Waveney ward. 71% of nursing staff had completed cardiopulmonary resuscitation (CPR) and defibrillation training .
- There was a well-equipped treatment room with a range of clinical equipment where consultations for physical health care could occur
- There were seclusion rooms to manage disturbed patients away from the main patient area. Staff could clearly observe a patient in the seclusion room and there were no blind spots. A clock was provided that was visible from inside the seclusion room. A closed circuit video camera was provided outside the seclusion rooms, to allow staff to observe and ensure the patient was safe.
- Bure Ward had no communication system provided. However staff told us they could hear through the seclusion room door and were able to communicate. This was confirmed by a patient in seclusion.
- The seclusion room on Walsham ward had an ensuite and was specifically designed to be low stimulus. All fixtures, furniture and fittings were suitable for seclusion rooms. The location protected patients' privacy and dignity and minimised interaction between secluded and non-secluded patients.
- On Redgrave ward the seclusion room did not have any furniture. We were told that a mattress was available and stored in a neighbouring room.
- On Wavrney ward there was no furniture in the seclusion room which had been used on six occasions immediately prior to our visit. Staff and a patient who had used the seclusion room confirmed that there was no bed available in the room.
- Staff on Redgrave told us that when the seclusion room was in use by a patient, that the quiet room was used as a seclusion room .This is contrary to the Mental Health Act Code of Practice.
- Patients reported and we observed that ward areas were visibly clean. The wards had reasonable furnishings and were well maintained. The ward was spacious, with wide corridors.
- Domestic staff cleaned the wards daily. Hand gels were available in each ward. However we observed a member of staff taking a bin bag out and rubbish from the bottom of the bin and not wash their hands afterwards. Infection prevention and control audit tools were completed each quarter by wards and presented to the infection prevention and control committee. 82% of staff had completed infection control training.
- The wards operated a safety alarm system to summon assistance from other staff on the wards to respond to any urgent issues. This helped to manage the safety risks of patients and staff.
- There were effective procedural security measures and operational policies and procedures that were followed to ensure safety of patients, visitors and staff.
- The physical security minimised the risk of patients from absconding and protected staff and members of the public. There had been no absences without leave for the previous 12 months
- We observed procedural checks being made going through air locks and contraband items posters were displayed. Knives and other sharps were accounted for on every shift and ligature cutters were checked every day. Staff knew where ligature cutters were kept and how to use them. We saw a health and safety and environment checklist that was completed each month by wards.
- An estates strategy was in place. Generally there was appropriate provision and maintenance of buildings, equipment and technology as well as the clear outlining of internal and external perimeters. On Bure Ward a cupboard in one lounge was broken and this had been reported to the maintenance team. We saw a soap dispenser had been broken by a patient in the shower

Is the service safe?

room a few days before. This had been reported to maintenance but was not yet repaired. There was a risk of patients using this to harm themselves. This room was locked to reduce this risk until repaired.

- Each ward provided a report to the board on incidents, safeguarding, seclusion and serious untoward incidents. These were shared with ward managers to discuss with their staff. We found the practice of using these to set team objectives and bring about improvement was not well embedded in the wards.

Safe staffing

- In September 2014 the hospital employed 313 substantive staff. Of these 52 were registered nurses. 28 were learning disability trained and the remainder mental health trained. The turnover of staff was low with 7 leavers (2.2%). The sickness rate was low at 2.5%. There were 8.5 whole time equivalent qualified nurse vacancies and 4 whole time equivalent healthcare support vacancies . A recruitment programme was in place to recruit more staff.
- Ward rotas showed agency staff were used to cover shifts and wards used the same agency staff members when possible. Between August and September 2014 Waveney Ward had 52 days in which one or more shifts had not been covered, whilst other wards had between 2 and 22 days. Staff were used from other wards to cover shifts depending on the level of risk. Managers were able to adjust staffing levels daily to take account of the patient mix. They stated that where shifts could not be covered the nurse managers and nursing staff in administration duties could be redeployed. There had been no instances in the previous four months when nurse managers had to be redeployed to cover shifts.
- Two qualified nurses were present on wards. We did not see a qualified nurse present at all times in the communal areas as they were undertaking tasks in the office. We observed that there periods of time when a lot of staff were in in the ward or communal areas who were not engaged in patient activities.
- Arrangements were in place to deal with foreseeable emergencies. All staff we spoke with told us that they had a contact telephone number in the office to get support in an emergency or at night, weekend or bank holidays. Managers confirmed that there was an on call manager and consultant provide support to staff when needed.
- We saw two new staff members who were being inducted on Waveney ward. Staff reported that it was used for inducting new staff as it was usually more settled.

Assessing and managing risk to patients and staff

- There were a number of risk assessment tools used by clinical teams which were detailed and regularly reviewed. 87% of nursing staff had been trained in clinical risk management as part of the annual mandatory training.
- Risk assessments sampled identified the risks to the individual and how these were to be minimised. We saw detailed behavioural management plans and management of aggression care plans These were updated regularly.
- Records showed ,and one patient told us, that staff checked to ensure the mood of the patient was settled before they went out on leave to ensure their safety.
- Patient toiletries that could be used to self harm were kept in the staff room and patients had to ask for them. This was a blanket restriction, rather than based on individual risk assessments.
- There were restrictions on when all patients could have hot drinks and when they could smoke. Risk assessments were in place to ensure that patients who could do so could keep their own cigarettes. A electric lighter attached to the garden wall was available to reduce the risks of patients having their own lighters.
- All patients were searched on return to the ward from leave even if they had been escorted by staff and room searches took place monthly. This was to ensure that patients did not have access to items that could cause harm to themselves or others. Staff told us that patients were informed of this on their admission to the ward. However the MHA Code of Practice requires consent to be obtained and individual risk assessments, and procedures where consent is not given to be followed. We found no records to demonstrate this had been done.
- 84% of staff had completed special observation and recording training as part of the annual mandatory training. We saw patients being observed during our visit. Observations took place in a positive and friendly manner, with support workers using them as an opportunity to interact positively with the patients. On Walsham ward we saw, and staff told us, that there were

no breaks in between observations. Staff moved from one patient to the other when they undertook one to one observations. There were seven people on special observations, with two patients on a two to one.

- The Patients' Council and three patients reported that people felt unsafe on the wards because of patient on patient assaults, patient bullying and sexual harassment. All the patients who were concerned told us that they had reported the incidents and that staff had supported them afterwards. We saw that the wards increased the chances of patients getting into confrontational situations when all of them were sat around the main sitting area unoccupied , when access to their bedrooms was denied. We saw staff responded calmly and positively to patients when they were agitated and used de-escalation techniques. However we question whether consistent use of de-escalation techniques were being effectively used given the number of incidents, restraints and seclusion.
- There were 179 episodes of seclusion between the 1 April and 30 September 2014 of which 103 occurred on Redgrave. Other wards reported there had been a reduction in the use of seclusion. The hospital provided an audit report dated 10 April 2015. This audit showed that women had higher rates of seclusion. That the number of seclusions generally lasted under two hours and that the seclusion rates were falling on a monthly basis on all wards.
- We were concerned about the high number of physical interventions carried out. There were 684 episodes of restraint between 1 April and 30 September 2014. There was one patient who had very high numbers of restraint within these figures. Prone restraint was used with 33 patients (23 women and 10 men). On 290 of the 684 occasions the patient was restrained in the prone (face-down) position. 56% of the prone restraints related to one patient. Restraints were reported as incidents and restraint forms with body maps completed. The incidents were linked to the care notes and reviewed by the clinical team. We also noted that restraint was often used to take the patient to the seclusion room. This was recorded appropriately. The Department of Health guidance published in April 2014 states that planned or intentional prone restraint should not be used. The guidance also calls for providers to implement restrictive intervention reduction programmes. The managers of St. John's house had established such a programme. A restrictive intervention audit dated 10 April 2015 showed that the number of restraints per month were falling during 2014.
- The seclusion records indicated that the periods of confinements were appropriately monitored; The duty doctor was contacted on each occasion; and there was a clear log of when seclusion was terminated. We only found only one clear record of the doctor attending a seclusion lasting four hours in accordance with the MHA Code of Practice guidance. There was one patient in long term seclusion who felt that the hospital did not meet their needs. Staff acknowledged that the needs of this patient were not adequately met. Reviews were taking place and records of seclusion were well documented. Staff told us that referrals had been made to other hospitals but no suitable place had been identified. A plan was in place to gradually re-integrate the patient to the ward. A bedroom and sensory room were being renewed according to the needs of the patient to move them out of the seclusion area.
- Staff told us that following the Winterbourne View report, the hospital had focused their training in the learning disabilities service and had put additional emphasis on safeguarding and least restrictive practice. The hospital had an action plan in place following an audit against the Department of Health "Positive and proactive ;reducing the need to restrictive interventions".
- 78% of staff had completed breakaway training, 80% of staff had completed de-escalation training , and 80% of staff had completed management of aggression and violence (MVA) as part of the annual mandatory training this year. The uptake of training needs to be increased to make a significant impact in reducing the number of restraints, seclusions and incidents.
- 62% of staff had completed rapid tranquilisation training as part of the mandatory annual training .The hospital reported that there had been 55 instances of rapid tranquilisation used between 1 April 2014 and 30 September 2014, of these 23 were given during a prone restraint. Patients were monitored following this to ensure their safety and wellbeing. We saw that the provider's rapid tranquillisation policy had been followed by staff who prescribed medicines to be given in an emergency.

Is the service safe?

- Since April 2014 there were three Reporting Injuries, Diseases a Dangerous Occurrence Regulation (1985) notifications to the health and safety executive due to patients assaults. The risk and care plans of the patients concerned were reviewed soon after the incidents..
- Medicine management mandatory training was taken up by 60% of staff as part of the annual mandatory training. Permanent and agency nurses undertook an annual medicine management competency review.
- Medicines were stored safely. Controlled drugs were stored and dispensed in a safe manner. Daily checks were undertaken to ensure that medicines were given to each patient as prescribed. Agency and bank staff had to complete a medicines competency assessment before they gave patients their medicines to ensure they had the skills and knowledge to do this. Medicines were disposed of safely and this was recorded.
- All patients had an individual medication folder. We found that generally the prescription folders were neat and well presented. Most files had a patient photograph available (we were told that patient had consented to this) and each patient had a hospital passport which was written in an easy read format.
- A pharmacist visited each week to check medications, stock and prescription charts.
- Clozapine medication monitoring was carried out by the practice nurse and GP to make sure it was given in safe levels and look out for side effects. The pharmacy did not dispense medication until the results were available. Nurses on the wards were aware of the side effects.
- There were clear guidelines on reporting safeguarding issues. 87% of staff had received safeguarding vulnerable adults training. Staff we spoke with demonstrated that they knew when and how to report safeguarding issues to protect patients from harm. We saw that information was easily accessible to inform staff on how to report abuse.
- There were 72 incidents reported to safeguarding which were investigated between April 2014 and October 2014. A safeguarding meeting occurred six weekly involving the local authority, police and the internal safeguarding leads.
- The "safety thermometer" was used; there were no reports of falls, pressure sores, venous or thromboembolism from April 2014.
- Social workers determined if it was in the best interests of the child to visit inpatients. Family rooms were available off the wards to support visiting.

Track record on safety

- There were 110 instances of self harm reported between April 2014 and November 2014 occurring on the wards. Individual instances were discussed in the clinical team meetings and risk plans reviewed.
- The National Patient Safety Agency preventing suicide audit was carried out in 2014 year showing compliance with the standards. It showed that staff received generic training on clinical risk management but not suicide risks specifically. There was a suicide and self harm training package available. Assessing and managing risk of self harm and suicide training was attended by 19 staff in 2012, and by 21 staff in a team meeting covering the topic in 2013. The training was not mandatory.
- A longer term management of self harm audit was carried out in July 2014 to monitor compliance against NICE guidance and there was a high level of compliance reported.
- There were five serious untoward incidents that were investigated relating to allegations of physical and sexual assault between December 2013 and 18 November 2014. Lessons learnt were identified and actions implemented.

Reporting incidents and learning from when things go wrong

- There was an electronic system to record incidents and near misses. All the staff we spoke with clearly demonstrated how they would identify and report incidents. We saw that incidents were reported and investigated. Staff told us that they received feedback following incidents through staff support meetings and information was circulated within the team. Staff reported that debriefings took place following incidents.

Is the service effective?

Our findings

Assessment of needs and planning of care

- Assessments were carried out before admission and after admission. Three records sampled on Walsham ward showed that comprehensive assessments had been completed on admission which covered all aspects of care as part of a holistic assessment. A 72 hour care plan was initiated on admission and reviewed and updated through the clinical team in a timely manner.
- We sampled 13 records which included care plans that were person centred and holistic. A multidisciplinary care plan audit was undertaken in September 2014 and a recovery audit. This showed the majority of patients had a care plan and actions had been identified for the following three months.

Best practice in treatment and care

- National Institute for Health and Care Excellence (NICE) guidelines were followed in the prescribing of medication and psychological therapies offered.
- Records and patients confirmed they had a physical health care check when they were admitted and annual reviews took place. Their physical health was regularly monitored. All patients were seen by a GP within 24 hours of admission. All patients were registered with a local GP. A male and female GP carried out clinics at the hospital once a week. A practice nurse was based at the hospital to support physical healthcare. The practice nurse or GP saw patients following physical interventions and checked for bruising which was recorded.
- Records confirmed that monitoring of weight, blood pressure, ECGs and blood investigations was carried out. Patients confirmed they had access to a dentist, chiropodist and optician. Women had the choice of going to the GP practice for a cervical smear or in the hospital.
- All records included a hospital passport to ensure that if a patient needed to be admitted to hospital for their physical health care needs, the staff there would know how to meet their needs and support them. There were good recordings in physical health plans.
- The hospital provided data stating that 32 patients had received flu vaccinations with a further eight planned to receive it. Staff were also offered free flu vaccinations and 54 staff had received it. No records were kept of staff who had made other arrangements to receive the vaccine.
- Patients had access to a range of staff that supported a varied programme of activities linked to individual activity and care plans such as dedicated clinical psychologist and an assistant, an occupational therapist (OT); a social worker; gym instructor; technical instructor; and consultant psychiatrist.
- The ward teams had established a therapeutic base for interventions. Staff showed us evidence of clinics held, which included dialectical behavioural therapy (DBT), positive behaviour support and sex offenders treatment programme . The teams consisted of staff trained in DBT. The nature of the issues people presented with often led to referral on for psychological therapies following assessment.
- The hospital had published articles into their successful use of mindfulness and positive behaviour support. Records indicated patients were provided with psychological input to mindfulness and solution focussed therapy. We saw that people had access to talking therapies on a one to one to support them with their emotional well-being.
- Staff told us and we saw that positive behaviour support had started to be used in the hospital. Patients were given copies of the plan in an easy read version. This helped to ensure safe and effective practice when working with the patients at the hospital. Staff told us they had received training in this, which were confirmed by training programmes viewed.
- We saw that the hospital carried out outcomes satisfaction survey where people gave a summary of the care and treatment they received. The results showed that most of the people were happy with the care they received and had been given information about their medication and side effects.
- The hospital used some outcome measures to determine the effectiveness of the service which they provided. We saw that the hospital used health of the nation outcome scores (HoNOS-S), which is an outcome measure which decides the progress of therapeutic intervention for individuals. HCR-20 was also used to estimate a patient's probability of violence based on historical clinical information. Both of these were monitored by the hospital dashboard.
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Is the service effective?

Skilled staff to deliver care

- There was a range of mental health and learning disabilities disciplines involved in delivering care. These included OT, speech and language therapist, social workers, psychiatrists, nurses, psychologists, care workers and practice nurse.
- Health care support workers told us that they had to complete the level three diploma training, but had to do this in their own time as they did not have time during their working hours. The hospital confirmed they provided five hours of learning time per month for all its staff, for longer courses there was negotiation for some of the learning to be undertaken in the staff own time.
- Some staff told us that they had received training so they could train other staff in the management of violence and aggression which was accredited by the British Institute of Learning Disabilities. They expressed concern that the additional training had to be done on their days off.
- Staff received further training in different areas of their specialities. The team had nurses trained in areas such as epilepsy, autism, challenging behaviour, DBT and positive behaviour support.
- The hospital provided a programme of induction, mandatory training, management supervision and appraisals. Clinical supervision was provided when people wanted it rather than regularly. We saw evidence of staff support minutes where peer group support took place.

Multi-disciplinary and inter-agency team work

- Records showed that the MDT worked together as a team following the care programme approach framework. Patients attended their review meetings and some chaired them.
- Some of the health care support workers told us that they were not listened to in clinical team meetings. This meant that some of the information about patients might not be discussed which could impact on their care and treatment.
- Information shared about patients in handovers was written down to ensure all staff were clear about how to support each patient. We saw records that confirmed information was passed on in handovers.
- A night shift handover was observed which took 15 minutes and was attended by all day staff. A detailed handover sheet was completed and provided the basis of the handover. Patients' changing risk was discussed.

MHA and the MHA Code of Practice

- Staff had access to the Mental Health Act Code of Practice. 87% of staff had received Mental Health Act training. Induction programmes also included training in the Mental Health Act.
- Detention paperwork was filled in correctly and was up to date and available in the patients' records we reviewed. With the exception of one patient file where there were no copies of the original section papers and no copy of the recent authorisation form. Four files did not contain the initial approved mental health professional report**.**
- On the day of our visit there were 22 people on civil sections and 26 patients on forensic sections.
- Patients were informed of the independent mental health advocacy service and also had access to generic advocacy services.
- Records and patients confirmed that rights under the MHA were provided regularly. Information about this was provided in a format that was easy to read.
- Section 17 leave had been authorised appropriately for all patients and that Ministry of Justice approval had been obtained appropriately for restricted patients in the records reviewed. All patients that we spoke with were aware of their leave status and knew how many escorts that are required to escort them during leave. Records reviewed did not show that patients' were provided with a copy of their leave authority. In some records the staff grade of the escorts required to carry out leave for patients was not clearly specified on the leave authority.
- Section 17 leave was sometimes delayed because of the availability of staffing and agency staff could not take patients out on leave. Staff said leave was always rebooked and that patient hospital appointments always took priority.
- Some patients reported that section 17 leave was cancelled due to staffing. We found that the hospital monitored leave taken. The Patients' Council selected section17 leave to be audited in January 2014. During

the audit period out of 118 planned leave episodes 14 did not happen. The most common reason being, patients failing a mood test or due to staffing issues. The Patients' Council did not accept the findings and asked for another audit to be carried out. This was planned for December 2014. We observed the Patients' Council meeting where this issue was still a concern.

- The Patients' Council reported that they would like to see other activities available for section 17 leave such as laser quest, group trips and activities in the early evening. Staff told them they could not do activities that occur after 5.30pm nor go to places such as Alton Towers without giving a considered rationale.
- Patients were not aware of the Care Quality Commission (CQC) and we did not find information on display relating to the role of the CQC with contact details.
- Patients spoken with were aware of their right to appeal to a Mental Health Review Tribunal which was evidenced in the documentation.
- All assessment of capacity and consent to treatment records were available and well recorded.
- We found that not all statutory consultees recorded their discussion with the second opinion appointed doctor (SOAD). Records that the responsible clinician had discussed with patients the outcome of the SOAD's decision about their medication treatment were not always available. These recordings should have been made with regard to the MHA Code of Practice guidance.
- Up to date certificates of treatment were stored with the drug chart.
- We looked at prescription cards and found that one patient had been prescribed more medication than had been authorised on the treatment certificate authorisation form. One patient had two prescription cards that had the same drug prescribed twice (once on each chart) and that one of these had not been cancelled leading to a potential medication error. Another patient was prescribed a medication that could be given by an injection or taken by mouth. The prescription chart stated both could be used but without clear instructions in what situation this medication should be given in a particular way. These issues were highlighted to the clinical manager on Redgrave Ward as they were discovered.
- Records reviewed showed that emergency treatment under section 32 of MHA was used to authorise certain medications for two patients. However no referral had been made to have these reviewed by a second opinion appointed doctor.
- Associate hospital managers' held hospital managers, hearings as part of the patients right to appeal against their detention. No patients had been discharged from their detention by the associate hospital managers. There was an induction process in place for associate hospital managers and they had access to legal advice.
- MHA managers and senior clinical team meetings were held six monthly and discussed patient activity and complaints. The minutes we reviewed did not identify how the group looked at Mental Health Act monitoring and administration.

Good practice in applying the Mental Capacity Act

- No Deprivation of Liberty Safeguards (DoLS) applications had been made in the previous six months.
- Staff told us that the mental capacity of each patient was assessed. We saw best interest meeting records on Walsham ward .
- Staff received Mental Capacity Act training in their induction programme.

Is the service caring?

Our findings

Kindness, dignity, respect and support

- We observed that staff were caring, respectful and interacted positively with patients. They gave subtle and practical support when needed and worked well to engage patients positively. We saw staff engaging well and effectively encouraging patients to participate in activities such as cooking, playing board games and talking socially with them in a respectful manner. Staff gave one to one attention in a sensitive manner.
- Patients reported that they could talk to staff and were listened to. In the period August 2014 to October 2014 primary nurses achieved 100% one to one sessions with patients in August, however this fell to 98% in September and fell further to 62% in October. Patients reported that they felt supported and looked after well by the clinical team.
- Staff we spoke with had a good understanding of patients' particular needs. Some patients we spoke with reported that agency staff did not know them or their needs and this sometimes made them feel unsafe.
- Patients we spoke with were positive about the contact they had with their family. Some patients had visits arranged to see their families. Some patients told us about the difficulties families had to visit due to long distances. An audit relating to family visits for the period 2011 to 2012 showed there were 177 home visits which was an average of two visits per patient. Patients were able to have home leave up to four times a year. There were ten patients who did not have a home visits.
- There were three family rooms provided within the hospital. Whilst the uptake was low, patients were supported to keep in contact with their families and friends through Skype. This meant that their relatives could see them on the ward and their surroundings as they were not allowed to visit them on the ward for security reasons.
- A private pay phone was provided on the wards. As a result of feedback from patients some mobile phones were being provided on the ward so they could speak longer with their relatives and friends.
- A "ward to board" report was provided to the board and ward manager in relation to active care plans, community meetings and the number of primary nurse sessions held with patients individually.

The involvement of people in the care they receive

- When a patient was admitted to the ward they were allocated another patient as their 'buddy'. This helped the patient to settle in and be orientated to the ward.
- All patients had an physical health checks on admission and annually. We saw that this was monitored. All patients had health plans. Records we sampled did not show that the patient was involved in developing their health action plan. We saw that patients had their copy of 'my shared pathway' in their bedrooms. One patient told us they had a 'my shared pathway' so they were aware of how their care was currently planned, however they did not know much about the plan for their discharge.
- Weekly patient meetings were held on the ward to discuss issues. One patient told us this was useful in helping to talk about the issues of living together, 'house rules', reducing bullying, planning for section 17 leave and the ward health and safety. We saw minutes of meetings that confirmed this.
- Information about how to contact advocates was displayed on the ward. Patients told us that advocates visited the ward weekly and that they knew how to contact them. Advocacy confirmed that people self referred.
- The friends and family test had been introduced. Due to the low number of participants we could not evaluate the results relating to the hospital.
- Patients reported they were involved in their care reviews and were free to air their views. Records of clinical team meetings showed that patients and their family members' views were taken into account and they were supported to make informed choices. Staff told us that patients' families were involved in the assessment and care planning where appropriate.
- Advance decisions were not found in the records reviewed and did not appear to be promoted.
- There was a patient representative who was due to undertake interview skills training in order to be involved in the recruitment of staff.
- In 2013 the hospital carried out audits using the essen climate evaluation schema ,a 15 item questionnaire, developed for assessing the therapeutic climate within a

Is the service caring?

care setting. It explored the degree to which service users felt safe and supported by both their peers and care staff. The audit was carried out across four hospital locations which included three wards from St John's House and therefore the results were not specific to this hospital. the majority of patients considered patients' cohesion and mutual support as low. 44% of patients considered the ward safety to be either low or very low across the four PIC hospitals. In respect of therapeutic hold, (i.e. climate is perceived supportive for therapeutic need), the findings overall from 2013 was considered to be good. The results for 2014 were not available.

- A patient satisfaction survey was carried out in May 2014 within the Assessment and Treatment and the Rehabilitation Services at PIC Learning Disability Service which covered four locations including St John's House. The results available were not specific to St John's although 35 out of 79 participants were from St John's. The results overall were largely positive. For example the purpose of medication had been explained , and people had been given information about their rights, 50% of patients had been encouraged to use the internet.
- A carers and relatives report was carried out by the provider in May 2014 across four of its learning disability service locations which included St John's House , the results were therefore not specifically for St John's. 68% were kept up to date with their relatives circumstances. 63% found it easy to get in touch with the ward . However not all felt consulted and involved in CPA meetings. Not all had received information about rights as the nearest relative. for 72% of respondent travelling distance affected their ability to visit.

Is the service responsive?

Our findings

Access, discharge and bed management

- Patients were admitted from all over the UK. Eight of the 48 patients were from the East Anglia area, with many people from London, West Midlands and Wales.
- Each ward had a philosophy of care document. There were clear admission standards set down. Any referrals received were assessed by at least two members of the clinical team and then followed by a clinical team meeting to ascertain if they could meet the needs of that particular patient.
- The average length of stay for the medium secure ward was 18 months, and for low secure wards between 12 and 16 months.
- Staff told us that they had effective links with local care coordinators. They said that when a patient was being discharged they had overnight leave to their new placement. The hospital discharged approximately 15 patients per year, and had 2 delayed discharges. Only four people had been readmitted from step down facilities.
- The wards were operating to full capacity, and all people on leave were able to access their bed on return.
- The majority of records showed coordinated discharge plans and good links with the placing authority. The clinical team involved patients and their families in the discharge planning. Patients were discharged into lower levels of security which included low secure, rehabilitation or community setting. Patients could also step up to more secure settings,should their circumstances change to meet their needs. We noted in a discharge meeting that reasons for not discharging a patient were clinical ones and delayed discharges were due to unavailability of a suitable placement to meet the needs of patients in their home areas. Some patients were able to confirm they were viewing placements elsewhere.

The ward optimises recovery , comfort, dignity

- Patients were not allowed to access their bedrooms during activity periods between 9.30am and 1pm and between 2pm and 4.30pm.
- There was a mixed picture of patients' perceptions of activities from the patients we spoke with. Some patients reported having enough activities to meet their needs; others told us that activities were limited on the wards particularly on weekends. Many patients told us that the activities available to them were the ones that were not of interest to them. We saw that there was a detailed activities timetable on the ward but this did not take into account individual interests. We saw that some patients were playing board games with nursing staff.
- The hospital monitored the amount of activities offered and taken up and reasons why activities may not be taken up by patients. Between 17 November 2014 to 23 November 2014 the number of planned meaningful activities offered on the wards was 2,576 of which 1,099 were not taken up. The reasons for lack of uptake related to the patients non engagement, being unwell , cancellations and in some instance the reasons were not recorded.
- We saw that there was an activity timetable for the week in picture format which made it easier for patients to understand. An OT and assistant were employed on weekdays. Activity coordinators were employed to provide more activities in the evenings and at weekends. Three activity coordinators told us they were provided with little money to provide activities which limited what they could offer.
- Records confirmed patients had access to life educational vocational occupational service provided by support time recovery workers who work alongside the OT to provide ward based specific activities, the hospital informed us that forty-three patients had access to the programme.
- Wards had separate lounge where patients could have space away from others. Separate activity rooms and therapy rooms were provided and clinic room to examine patients.
- Patients reported that they did their own laundry with support from staff. This promoted their independence.
- People had access to outside spaces , although two patients reported they did not have enough access to fresh air.
- Visitors were not allowed on the ward area and patients met their visitors in one of the three family visiting rooms out of the ward area.

Is the service responsive?

- Patients could make a phone call in private. Calls were limited to 15 minutes by staff so that all patients could use the phone. Some wards had responded to patient feedback by providing more mobile phones , so that they could speak for longer.
- Smoking was permitted within the hospital court yard areas at designated times between 7am and 7.30pm.
- Patient bedrooms were personalised. All patients were provided with a TV in their bedroom if they wanted this. Patients reported they could watch TV whenever they wanted in their bedroom as long as this did not affect their sleep pattern. Patients could have their own key to their bedroom if this was safe for the individual.
- The Patients' Council minutes were reviewed and a meeting was observed. It was attended by patients and staff. Patients said that same issues were raised which were not dealt with. Issues raised; related to staff shortages affecting activities. staff spending too much time in the office instead of with patients, agency staff not knowing the patients history and needs causing patients to feel unsafe. Patients asked if a trip to Alton Towers could be planned as the hospital had transport. They were told this was not possible. During the meeting a member of staff kept coming in to see if the meeting was finished. Staff did not interact well with the Patients' Council because they did not respond or give adequate explanations.
- Patients' community meetings were held on the ward weekly and minutes maintained. Standard items discussed were health and safety, food, leave, bullying, activities and living together.
- Learning disability patients had won over 30 Koestler Art Awards over the last five years.

Meeting the needs of all people who use the services

- There was information on treatments and services, patients' rights and how to complain, but this was not written in an easy to understand format. It also did not give patients full information about what to expect on the wards, for example, searches, routines and restrictions.
- There were information and leaflets available to be given to patients on the initial assessment to explain and help them understand how the ward worked and what to expect.
- 73% of nursing staff had completed equality, diversity and human rights training. Staff told us that the ward could meet the diverse needs of patients; however the current patients did not have diverse needs. However a minority of patients spoken with told us that their diverse needs were not met.
- There was a designated multi-faith room which was not used for this purpose, as there was a TV and sofas in the room and patients were using it as a lounge to watch TV. This meant that people wishing to express their spiritual and religious needs, in a quite space could not do so.
- Patients had the opportunity to meet their religious needs by attending church services and being supported to see a chaplain on request. However one patient told us that they had been on the ward for six months and had not seen a chaplain when they wanted to. They told us that they had never had a leave facilitated to go to church on a Sunday.
- No information was available in in other languages. Staff told us that they can access interpreters when needed.
- At the time of our visit there were no choice of food that was available to meet dietary requirements of religious and ethnic groups. A manager told us that this can be made available through the kitchen.

Learning from concerns and complaints

- There were 76 complaints made in the previous 12 months of which 48 were upheld. 87% of nursing staff had completed complaints training. Staff were expected to update every three years.
- Overall the hospital had a complaints system which was managed well. However patients had mixed views of their understanding of the complaints procedure. A few reported that they did not know how to complain or understood the process. Some patients said that they understood how to make a complaint and had made complaints that were resolved satisfactorily. Some patients told us they were unsure if their complaints had been investigated. Further work needs to be undertaken to ensure patients know how to complain and how they are kept informed of investigations.
- On reviewing the complaints register, the complaints appeared to be resolved locally with the complaint record indicating that the patients were satisfied with the outcome. We found one complaint was a

Is the service responsive?

safeguarding concern which was managed using the safeguarding procedures. We saw records of informal complaints that were logged by the manager and how they responded to patients.

- Safeguarding and complaints were linked. All complaints and safeguards were reviewed and decisions made as to whether the safeguarding team investigated alone or jointly with the hospital, or the investigation took place locally. Patients were provided with letters about the actions being taken and outcomes. Patients were able to comment on the outcome and if not satisfied were able to appeal to the complaints officer.
- There was a report from each ward that provided information to the board and ward managers about complaints.

Is the service well-led?

Our findings

Vision and strategy

- All the staff we spoke with, knew who their senior managers were and told us that they had seen some of them quite often on the wards. Staff reported that the chief executive officer held annual road shows.
- Staff on Walsham ward demonstrated a good understanding of their ward objectives and were able to link them with the organisation's values and objectives. Other wards did not have team objectives.

Governance

- A "ward to board" report provided information to the board and ward managers on occupancy, length of stay, leave, activities and patient pathways , the use of this dashboard was identified as a clinical priority for 2014/15 and was not embedded in ward objectives to demonstrate improvements.
- There was a structure in place in which reports went from the ward to the organisation's board. The reports went to the hospital's management and clinical governance committees reported to management and clinical governance committees at regional and corporate level. The latter reported into the board.
- There was a MHA administrator to monitor the administration of the Act and remind professionals of statutory timelines to ensure that the detention process was lawful. A MHA managers and senior clinical managers meeting were held twice a year.
- There was a comprehensive learning disabilities risk register which identified a range of potential risks such as potential business risks, potential risks to the public and IT failures . We were informed that actual risks such as restrictive practices, were reflected in the corporate and local service objectives. We were provided with an incomplete clinical governance draft action plan. The local clinical governance plan described the implementation of objectives. However did not describe the risks and mitigating actions.
- Staff told us that the governance team analysed the risks within the organisation and that this information was shared with all staff to reduce risks to safety. A "ward to board report" provided ward managers with key performance indicators relating for example to incidents, safeguards, seclusion and staff sickness . The use of this was not yet embedded into team objectives and ward plans to make improvements. Not all ward mangers were able to say how the information was used by them and whether the trends were going up or down in their ward.
- All new policies were identified and communicated to staff through staff meetings and supportive groups and emails. We saw minutes of regular staff meetings where discussions about new events, issues from patient meetings, updates, incidents, safeguarding and complaints took place.
- Staff understood and used procedures to report complaints, incidents and safeguarding concerns. Learning from these was discussed in staff support meetings, ward meetings and handovers. Staff told us that they received debrief and psychology support when incidents occurred.
- We heard positive responses from staff regarding management and staff forums, such as support meetings and away days for the teams every three months. We saw that the wards were well led in that systems ensured they were sufficiently staffed.
- The hospital reviewed itself against the Winterbourne View hospitals serious case review recommendations in February 2014 and had an action plan in place which was reviewed at service governance meetings. Some of the actions had been achieved , with many on track for completion by December 2015.
- The hospital had a revised positive behaviour support strategy action plan in place incorporating the audit findings against the "positive and proactive – reducing the need for restrictive interventions" (DOH April 2014). However the high number of restraints , many of which were in the prone position, led us to conclude that the provider still had much to do.
- There was 100% compliance in relation to appraisals and managerial supervision. Personal development plans were in place for all staff. Mandatory training was monitored by the hospital.
- Qualified staff we spoke with reported that ward managers were supportive and did listen and were open to new ideas. They told us they also received good

Is the service well-led?

support from the training and development manager direct on the ward to help them support patients with complex needs. Ward managers were supported by administrative staff on the wards.

- Healthcare support workers told us that they had to book their annual leave a year in advance, this meant that they often did not get their annual leave when they wanted it. They said this did not respect or value them and contributed to their low morale.

Leadership, morale and staff engagement

- Qualified staff told us that they were encouraged to access clinical and professional development courses if they were beneficial in meeting the needs of their patients. Staff were supported to attend leadership courses and mentorship courses.
- Generally, professionally qualified staff told us that all members of the team were valued and respected regardless of profession or level of position. We were able to observe staff working in collaboration and saw documentation of constructive working relationships. Professionally qualified staff felt there was good support from senior management. They told us that the senior management listened to them or get them involved
- Healthcare support workers had a different perspective to qualified staff. Staff said that on every shift they worked over their hours. However, the system to manage the time they were owed was not transparent which meant they did not know how much time owing they had accrued. The Health care support workers we spoke with told us that they did not feel valued for the work they did by senior managers. They thought that they should be involved in staff recruitment to give potential staff more ideas as to what was expected of them and reduce the turnover of staff. Healthcare support staff perceived that all emails sent by senior managers were negative and they were not thanked when things had gone well.
- Clinical team meetings were held regularly and involved a range of health professionals. There was also input from activities co-ordinator and the training and development manager
- Sickness and absence was monitored and the levels were low. The communication and understanding of staff benefits need to be clearer.
- Staff we spoke with told us the senior managers informed them about developments through emails and meetings and sought their opinion through the annual staff survey. The staff survey results for 2014 were generally positive.
- Staff we spoke with were aware of internal and external whistleblowing policies and where to find them. Anti-bullying and grievance policies were available to staff. All the staff we spoke with told us that they would feel comfortable raising concerns with their managers.
- The hospital provided training to student nurses and professions allied to medicine. Newly qualified staff had a preceptorship package and a competency folder to achieve. Staff reported receiving a good induction package with access to clinical supervision on request and managerial supervision every six weeks.

Commitment to quality improvement and innovation

- There was a system to monitor performance called “ward to board”. We saw that an analysis of the team report was available which had details of incidents, complaints, safeguarding, staffing, care plans , community meetings and primary nurse one to one sessions with patients. However, there was no broad range of detailed analysis of all key performance indicators to formulate trends, identify key areas that need improvement and how this was shared with staff, patients and their relatives. No team action plans were in place to address key areas of improvement.
- The hospital had a clinical audit plan in place which was a mixture of responding to national audits, CQUIN and some local audits. The management of aggression care plans were audited by senior nurses, the majority of patients had these in place.
- The hospital EssenCES audit was completed twice in 2014 to measure patient cohesion, the ward climate, environmental safety, and how therapeutic the ward is. The survey collected information from patients and staff and the results were only available for 2013. 44% of patients considered the ward safety to be low. We found the information to change practice was not embedded in the wards as few staff knew the results.

Is the service well-led?

- The hospital was participating in the National Audit Office study relating to care services for adults with learning disabilities in England following the Winterbourne scandal.
- The Royal College of Psychiatrists' Quality Network for Forensic Mental Health carried out a peer review of medium secure wards in December 2013 and found that 85% of their medium secure standards were met and a plan was in place to address the recommendations..
- The clinical staff at the hospital had published 14 peer-reviewed journal articles over the last three years. Two members of nursing ward staff were able to relate the research undertaken to the changes made in practice.
- The hospital host the clinical research group on forensic intellectual and developmental disability which brings together patients, commissioners, clinicians and academics from 25 NHS hospitals and 10 universities.
- The hospital was approved to offer learning disability training to specialty registrars in psychiatry.
- The learning disability services had achieved the British Institute of Learning Disabilities (BILD) physical intervention accreditation. This scheme accredits training organisations that deliver behaviour support and management training in conjunction with the use of physical skills or restrictive physical interventions.
- The hospital was a pilot site in 2012 for operating the "my shared pathway system" and we saw evidence of its implementation with patients.
- Senior managers carried out unannounced visits to talk to patients and check care. A six monthly compliance visit was carried out by a senior person from the company and detailed reports with recommendations produced. Results were generally positive.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 1(a) The registered person must ensure that service users are protected against the risks associated with unsafe or unsuitable premises by means of: (a) suitable design and layout **How the regulation was not being met** • Bure ward seclusion room did not have a communication system. • Waverney seclusion room did not have furniture.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 (1)b (iii) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of; reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. **How the regulation was not being met** The provider did not have regard to the Mental Health Code of Practice in that ;-

This section is primarily information for the provider

Compliance actions

- The clinicians had not documented the outcome of SOAD reviews of treatment; statutory consultees had not recorded their discussion with the SOAD.
- One patient had been prescribed more medication than had been authorised on the treatment certificate authorisation form.
- Patients using services had not been provided with a copy of their section 17 form.
- Blanket searches had occurred without take into account individual risk and consent.
- More medication was prescribed than the authorised treatment chart.

Regulated activity

Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
Regulation 9 (1)b (ii) (iii)

The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of;

- ensure the welfare and safety of the service user.
- reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.

How the regulation was not being met

The were 698 episodes of restraint, of which 290 were in the prone position.

Department of Health guidance is that planned or intentional prone restraint should not be used. The guidance also calls for providers to implement restrictive intervention reduction programmes.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.