Partnerships in Care Limited

St Johns House

Inspection report

Lion Road
Palgrave
Diss
IP22 1BA
Tel: 01379649900
www.partnershipsincare.co.uk

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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 ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was an unannounced, focused inspection in response to concerns regarding patient safety, incident management, safe staffing and the use of restraint.

We looked at specific key lines of enquiry during this inspection therefore we have reported in the following domains:

- Safe
- Well led

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

As this was a focused inspection, we did not inspect the domains of Effective, Caring and Responsive. Due to the concerns we found relating to the quality of care in other key questions, we have suspended the provider's current ratings within these domains. This suspension will remain in place until CQC is able to review this key question.

We rated St Johns House Hospital as inadequate because:

- The ward environments were not always safe. Ligature points were found in areas used for seclusion and ligature audits had outstanding actions which required completing to keep patients safe.
- Staff were not following infection prevention and control (IPC) measures to keep the hospital clean and to help prevent any infectious diseases from spreading.
- Staff on Walsham ward did not have access to working resuscitation equipment and the emergency bag checklist did not match the contents of the emergency bag.
- The service did not have enough nursing and support staff to keep patients safe and staffing was not structured in line with patient acuity and clinical need. Staffing levels were consistently below the number needed to maintain patient observations.
- The provider had not ensured that patient observations were completed in line with patient care plans or the providers patient observation policy. We found staffing allocations for observations were not completed and we reviewed CCTV footage where staff were asleep whilst completing patient observations.
- The provider had not ensured that all staff had completed or were up-to-date with their mandatory training. Only 56% of staff had completed their physical intervention training and only 62% of staff for their basic life support training.
- Staff did not always manage risks to patients and themselves well. Patients did not have adequate nursing assessments, associated care plans, risk assessments and positive behaviour support plans in place to enable staff to safely manage patients. Staff did not always act to prevent or reduce risks or respond to changes in patient risks.

Summary of findings

- Staff did not make every attempt to avoid using restraint. Levels of physical restraint were high, and between 1 November 2020 and 22 December 2020 there were 204 instances of physical intervention. We observed CCTV footage of seven patient incidents where we found that staff restrained patients using inappropriate techniques that were not 'provider approved' techniques taught to staff or proportionate to the risk.
- Restraint incidents frequently took place in sight of other patients and staff, as staff did not attempt to direct other patients away from the scene. Staff did not always support patients to stand up following restraint.
- The hospital had high numbers of incidents, some of which resulted in injuries to both patients and staff. The provider reported 273 incidents between 16 November and 13 December 2020, 158 of which were related to violence and aggression.
- Levels of seclusion were high, and patients were regularly secluded in side rooms as the seclusion room was regularly in use. Seclusion rooms and areas used for seclusion and long-term segregation were not fit for purpose and compromised patient dignity and safety. Patients in long-term segregation did not always have access to fresh air or activities. Patients did not always have lounge and en-suite facilities. Patients who were segregated on general corridors could be observed by other patients as staff kept the door open to complete observations.
- Staff did not keep clear records or follow the Mental Health Act Code of Practice when a patient was placed in seclusion or long-term segregation as records were incomplete and unclear. Nurses did not always complete meaningful seclusion reviews and reviews were not always completed when they should be.
- The service did not always manage patient safety incidents well. Staff did not report incidents clearly or as a true reflection of what occurred. Staff did not highlight the severity of the incident or transparently report the actions of staff during the incident. Managers did not fully investigate incidents and learning from incidents was not always completed or shared with staff. Staff did not always complete post incident checks with patients including checking for injuries or completing body maps.
- The hospital was not reporting all abuse or safeguarding allegations to CQC or the local safeguarding authority. Staff did not always demonstrate the values of the provider and incidents which we reviewed highlighted that staff did not always treat patients respectfully. There were four ongoing investigations, relating to the use of restraint from staff, in which staff were suspended from either working at the hospital or working directly with patients.
- Staff highlighted concerns with the culture at the hospital and felt stressed due to low staffing levels, patient aggression and wanted improved training and communication at the hospital.
- Our findings demonstrated that the providers governance processes were not operating effectively, and that performance and risk was not always managed well. For example, we found that incident reviews did not highlight key learning which could help to prevent incidents from occurring again. Risk at the hospital was not always managed well, as patients were exposed to harm due to low staffing levels and inappropriate use of restraint.
- The providers clinical governance meetings did not address key service risks as actions were not set to address all risks and concerns raised. The provider did not have an overarching quality assurance process of issues that had been identified.

However:

- Staff were able to give examples of abuse and managers held monthly safeguarding meetings.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Wards for people with learning disabilities or autism	Inadequate		

Summary of findings

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Summary of this inspection

Background to St Johns House

St Johns House is an independent hospital, part of the Priory group, that provides care and treatment for patients with a primary diagnosis of a learning disability and associated mental health problems. This includes autistic spectrum disorders, personality disorders and enduring mental illnesses.

The hospital was registered to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedure

The hospital had 49 beds across four wards. At the time of inspection 44 adults were admitted all of whom were detained under the Mental Health Act with some being subject to Ministry of Justice restrictions. St Johns House had four wards which were:

- Redgrave ward which was a 16 bed medium secure female ward. There were 15 patients on this ward.
- Walsham ward which was a 16 bed medium secure male ward. There were 13 patients on this ward.
- Bure ward which was a 11 bed low secure female ward. This ward was fully occupied.
- Waveney ward which was a 6 bed low secure female ward. There were 5 patients on this ward.

The registered manager of the service had been absent from the hospital since July 2020 and a temporary manager was covering this role.

The service was last inspected in July 2018 and was rated as good overall and within all five domains of safe, effective, caring, responsive and well-led.

How we carried out this inspection

This inspection was an unannounced, focused inspection in response to concerns regarding patient safety, incident management, safe staffing and the use of restraint. We carried out this inspection to look into these concerns and to explore the governance processes in place at the hospital.

We looked at specific key lines of enquiry during this inspection therefore we have reported in the following domains:

- Safe
- Well led

Before the inspection visit, we reviewed information from the service about recent incidents that had occurred. This included a review of incident reporting and management, CCTV footage, patient records, seclusion records, staffing levels and staff restraint data. We also received information from the local safeguarding authority and a patient advocacy service highlighting patient safety incidents.

During the inspection, the team:

- spoke with 11 patients who were using the service
- spoke with the temporary manager of the service and the Operations Director
- spoke with 11 additional staff from a variety of roles including ward managers, nurses, healthcare assistants, social workers and staff responsible for providing restraint training
- spoke with a range of stakeholders including NHS England and the local authority
- looked at seven care and treatment records of patients
- looked at 16 seclusion/long term segregation records of patients
- looked at staff records and training
- reviewed staffing levels
- reviewed infection control measures
- reviewed incident logs, forms and reviews
- reviewed safeguarding practices
- reviewed CCTV footage of incidents
- and looked at a range of policies, procedures, meeting minutes and other documents relating to the running of the service.

We spoke with 11 patients during the inspection. Feedback from patients was mixed, however, 6 out of 11 patients told us they did not always feel safe on the wards due to levels of aggression from other patients. Patients told us there was not enough staff to have regular 1:1 time with, activities were often cancelled due to too few staff and that staff did not have breaks. However, patients were complimentary about individual staff who were kind to them and supported them.

Areas for improvement

Following this inspection CQC took urgent action to prevent patient admissions at the hospital. The below requirements detail which regulations were not being met by the provider. The provider must send CQC a report detailing what action they are going to take to meet these requirements.

Action the provider MUST take is necessary to comply with its legal obligations. Actions the provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Action the service MUST take to improve:

- The provider must ensure that environmental risks, such as ligature audits, are completed and actions are taken to mitigate risks (Reg 12{2}{d})
- The provider must ensure that infection prevention control measures are taken to keep the hospital clean and ensure staff wear appropriate personal protective equipment (PPE) (Reg 12{2}{h})
- The provider must ensure staff have access to resuscitation equipment which is in working order and that there are appropriate assurances in place for staff checking the emergency bag (Reg 12{2}{e})
- The provider must ensure they have enough nursing and support staff to keep patients safe, to carry out physical interventions safely, to meet patient observations levels and to offer patients activities (Reg 18{1})
- The provider must ensure that patient observations are completed in line with patient care plans and the providers patient observation policy (Reg 12{2}{a})
- The provider must ensure that staff have breaks during the working day and that staff have breaks between completing patient observations (Reg 18{1})
- The provider must ensure that physical intervention is used as a last resort and in line with patient care plans and that appropriate physical restraint techniques are used safely and proportionately (Reg 13{4})

- The provider must ensure that all staff including agency staff have completed and are up to date with mandatory training for their role, including basic life support, safeguarding and physical intervention (Reg 18{2})
- The provider must repair the two-way communication system in the seclusion suite on Redgrave ward (Reg 12{2}{e})
- The provider must ensure that areas used for patient seclusion and long-term segregation are safe and fit for purpose (Reg 12{2}{d})
- The provider must ensure areas used for seclusion and long-term segregation protect patients' dignity (Reg 10{2})
- The provider must ensure that patients in long-term segregation have regular access to outside space, lounge areas and activities (Reg 13{7})
- The provider must ensure that seclusion and segregation records are completed in line with the Mental Health Act Code of Practice (Reg 13{4})
- The provider must ensure that staff work towards reintegration plans for patients in long term segregation and that these are evaluated (Reg 13{4})
- The provider must ensure that all patients have a nursing assessment and an associated care plan, a positive behaviour support plan and risk assessment in place and that these are personalised and updated in line with changes to the patient's needs and risks (Reg 12{2}{a})
- The provider must ensure that all staff are familiar with patient care plans, positive behaviour support plans and risk assessments to ensure staff can safely support patients (Reg 12{2}{a})
- The provider must protect patient's dignity during restraint by preventing other patients from observing where possible (Reg 10{2}{a})
- The provider must ensure they report all allegations of abuse (safeguarding) to CQC (Reg 18{2}{e}{CQC Registration Regulations})
- The provider must ensure that all safeguarding incidents which occur at the hospital are critically and thoroughly reviewed (Reg 13{3})
- The provider must ensure that learning from safeguarding incidents is identified, shared with staff and changes are made as a result of the learning (Reg 17{2}{b})
- The provider must ensure that the reporting of incidents is a true reflection of what occurred and that all incidents are recorded in patient records (Reg 17{2}{b})
- The provider must ensure that physical health checks and body maps highlighting injuries are completed for patients following incidents of restraint and self-harm (Reg 12{2}{a})
- The provider must ensure that governance meetings are effective in identifying areas for improvement and used to drive quality improvement at the hospital (Reg 17{2}{a-f})
- The provider must ensure they have appropriate assurance systems in place to identify areas of concern and to identify when policies are not being followed (Reg 17 {2}{a-f})

Action the service SHOULD take to improve:

- The provider should provide designated infection prevention control staff with appropriate training in infection prevention control
- The provider should record staff and patient debrief sessions following safety incidents
- The provider should ensure that informal patient complaints are recorded, alongside a response from the provider

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Wards for people with learning disabilities or autism

Inadequate

Safe	Inadequate
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- The ward environments were not always safe. Staff completed ligature audits, however there were uncompleted actions to mitigate blind spots and ligature points, such as installing a mirror and removing curtain rails to ensure all patients could be observed and ligature points removed. A ligature anchor point is something which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- We saw that most areas of the wards were clean during our on-site inspection. However, cleaning records were not fully completed, and staff were not adhering to infection prevention and control (IPC) measures. There were gaps in cleaning some areas of the wards and some dates were missing in cleaning schedules. The ward cleaning audit had not identified the gaps in the cleaning records and there were no actions set against cleanliness issues that had been identified in the audit.
- Staff were not able to evidence any additional cleaning measures taken in response to the COVID-19 pandemic. There was no evidence of additional cleaning of highly used equipment such as door handles, keyboards or phones. Staff were not able to confirm if patients' temperatures were taken unless they were symptomatic for COVID-19.
- We reviewed over 20 pieces of CCTV footage taken between August 2020 and December 2020 and within all CCTV recordings, staff were not wearing their personal protective equipment (PPE) appropriately and in some instances, staff were not wearing any PPE. Managers were not aware if staff had been fit tested to use FFP3 rated surgical face masks that are required when working with an infectious patient. However, during our onsite inspection, most staff were wearing their PPE correctly and the provider informed us they had been challenging staff who were not wearing their PPE correctly.
- Two infection prevention and control (IPC) leads worked at the hospital, however they were not provided with specific training for their role. IPC leads did not input into the providers environmental cleaning practices including cleanliness walkarounds.
- Seclusion rooms and areas used for seclusion and long-term segregation were not fit for purpose and compromised patient dignity and safety. We observed staff were opening the seclusion room door so that they were able to communicate with patients. However, we found that the two-way communication system in the seclusion room on Redgrave ward was not working. We observed the seclusion room door being shut on a patient's arm when the patient ran towards the door. Staff did not effectively manage this risk and they did not immediately release the door, leaving the patient's arm trapped. The seclusion room on Walsham ward was not clean and screws were missing from doors and walls. There were sharp edges on door locks and screws in the room were not countersunk, creating ligature points.
- Patients were often secluded in areas that were not seclusion rooms, such as side rooms. The side rooms had no en-suite facilities and patients had to be moved through communal areas to use the toilet or to use bedpans or urinals. Not all areas had window coverings. Patients who were in long term segregation in the seclusion suite did not automatically have access to a lounge area as the observation area of the suite was used by observing staff. Patients who were in long term segregation in their bedrooms did not have access to a lounge area. In addition, these bedrooms were located on general corridors where other patients were able to look into the room as the door was left

open to allow staff to observe. Patients in long term segregation were able to use a side room following a mood check deeming them safe enough to move through communal areas to access this. However, despite this process, a patient in long term segregation in their bedroom was able to assault other patients on at least three occasions in December 2020, when moving through communal areas.

- Patients in long term segregation did not have timetabled activity plans and the level of activities offered was inconsistent and limited. A patient in long term segregation did not have any access to fresh air for over eight days with no clear rationale and patients in prolonged seclusion were not offered access to outside space.
- We did not review all areas of the clinic room as this was a focused inspection however, clinic rooms did not have in-date resuscitation equipment as we found defibrillator pads that were out of date. Staff informed us that new defibrillator pads were being ordered after we highlighted this, but staff did not ensure contingency processes were in place whilst they did not have access to resuscitation equipment on the ward. Staff we spoke to were not able to tell us what equipment should be in the emergency bag. The contents of the emergency bag did not reflect the contents checklist. Staff were not able to tell us if the checklist was up to date, as the checklist was dated from 2015. The provider informed us they would be creating new weekly and monthly checks after we raised this with staff.
- The service did not have enough nursing and support staff to keep patients safe and staffing was not structured in line with patient acuity and clinical need. The provider had attempted to recruit additional staff however this had limited impact on staffing availability. Vacancies for nurses were 33% and 40% for healthcare assistants against the set staffing establishment. The service relied heavily on agency and bank staff. Up to 100% of staff on night shifts and up to 70% of staff on day shifts were agency staff. Not all agency staff were familiar with patients as some staff had completed a low number of shifts at the hospital. However, the provider told us that between August and December 2020, 91% of agency staff regularly completed shifts at the site. Staff were not receiving breaks throughout their shifts and staff were conducting enhanced patient observations for extended periods of time without a break. The service did not have enough staff on each shift to carry out physical interventions safely. We found that for one week in December, on average there were only seven out of 14 (50%) trained physical intervention staff on both Redgrave and Walsham wards.
- Staff and patients told us that there was not enough staff to have regular 1:1 time with and that activities were often cancelled due to too few staff. Staff told us that weekly activity timetables were often not followed, and an independent patient advocate told us that a patients Care Programme Approach (CPA) meeting had been cancelled due to staffing shortages as the patient could not be taken to the virtual meeting in the hospital.
- Consistently high levels of clinical observations were required for the management of patients, yet the establishment figure for safe staffing was set far below the actual numbers of staff required to be deployed on the wards. For example, at the inspection, 14 staff were needed on Redgrave ward during the day to meet the observation requirement. The set establishment figure for this ward was eight staff. Staffing allocations for patient observations were missing for various dates within November and December 2020, therefore we were not assured that patient observation levels were being met with adequate staffing numbers. For the dates where staffing allocations were available, we saw there were staff shortages below the required number. For example, for the five shifts that we were able to review using the available patient observation allocations, there were staff shortages across all five dates ranging from one to four staff below safe staffing levels on each individual ward. Furthermore, there were additional disparities between staffing rotas and staff timesheets. Staff timesheets showed even fewer staff present on shifts compared to the planned staffing levels.
- We reviewed a random selection of CCTV footage between 17 November and 12 December 2020 to observe how staff were managing patient observations. We found that in five out of five checks, staff were sleeping on duty. We found that when safety incidents had occurred, sufficient staff had not been deployed to undertake patient observation levels as directed in the patient’s care records. For example, in August 2020, prior to a serious incident, a patient had been observed by two staff members rather than three staff members who should have been observing the patient as directed by the patient’s risk assessment and care plan. Following a separate incident on CCTV in November 2020, we found this patient had one staff member on their observations, despite their care plan stating three staff members were needed due to the patient’s high risk of violence and aggression.

Inadequate

Wards for people with learning disabilities or autism

- Staff were conducting enhanced patient observations for extended periods of time. Records demonstrated that staff were continuously observing patients for up to eight hours without breaks. This does not meet the requirements of the National Institute for Health and Care Excellence (NICE) or the providers patient observation policy which states that staff should break between patient observations every 60 minutes to two hours.
- The service did not have enough staff on each shift to carry out physical interventions safely. During one week in December, on average there was seven out of 14 (50%) trained staff in physical intervention on both Redgrave and Walsham wards and that on one occasion, only one physical intervention trained staff member was available on shift on Bure ward. Furthermore, there were three incident reports made in August and September 2020 stating that there were insufficient Prevention and Management of Violence and Aggression (PMVA) trained staff members on the ward to manage incidents.
- The provider had not ensured that all staff had completed or were up to date with their mandatory training. Only 56% of staff had completed or were in date with their physical intervention training and only 62% of staff for their basic life support training. The provider informed us that agency staff were checked to ensure they had a minimum of breakaway training before working at the hospital. We reviewed agency staff training records which highlighted that four out of 12 (33%) agency staff were out of date with their breakaway training. The same four agency staff were also out of date for all other mandatory training including safeguarding adults, basic life support and infection prevention and control. The provider informed us that the COVID-19 pandemic impacted their ability to provide face to face training with staff.
- Of those staff trained in physical restraint, we were not assured that they were trained appropriately. When reviewing CCTV footage, we found restraint techniques being used on patients that were not 'provider approved' techniques taught to staff in their training and were not proportionately used with the patient. We reviewed CCTV footage of seven patient safety incidents which occurred between August 2020 and December 2020 and identified issues such as prolonged use of prone restraint, a patient being dragged across the floor despite attempting to drop their weight, a patient being pushed over and the seclusion room door trapping a patients arm and making contact with a patient's head when closed. Managers did not identify all concerns or appropriate learning from these incidents in order to prevent them from occurring again. Despite the provider suspending staff members from working at the hospital following some of these incidents, the provider had not reported all incidents to the police or the local safeguarding team. Following CQC raising this as a concern, the provider has now reported incidents to the police, the safeguarding team and has suspended further staff pending investigation.
- Staff did not always manage risks to patients and themselves well. Patients did not have adequate nursing assessments, associated care plans and Positive Behaviour Support (PBS) plans in place to enable staff to safely support patients. Although patient risk assessments were updated following incidents, the reviews consisted of a general note about the incident rather than information about what was working to manage patient risk, what was not working and what changes were required. Information was inconsistent on risk assessments such as the level of patient observations required. Staff completed Positive Behaviour Support (PBS) plans and patient care plans which were also both updated following incidents. However, information was often repetitive between patient records and lacked personalisation. For example, generic statements were used, such as to provide support 'through observations and engagement'. Patient care plans and PBS plans were detailed but complicated and not 'user-friendly', and as high proportions of agency staff worked at the hospital, we were not assured that all staff were familiar with patient risks. PBS plans were not reviewed to see if the plan was working to prevent incidents from occurring and staff did not always act to de-escalate patients in line with their PBS plans.
- Levels of physical restraint and seclusion were high. Patients were regularly secluded in side rooms as the seclusion room was in use. Between 1 November 2020 and 22 December 2020 there were 204 instances of physical intervention at the hospital. The majority of restraints occurred on Redgrave ward, with 115 instances of physical intervention in the same time period. The majority of physical intervention involved standing restraint but there were seven instances of prone restraint used. Prone restraint is a physical restraint technique to hold a person chest down.
- Staff did not make every attempt to avoid using restraint and did not always appropriately de-escalate patients. We observed CCTV footage of patient incidents to consider how staff had anticipated and managed violence and

aggression. We observed that the management of antecedent behaviour was poor and there was a lack of adherence to National Institute for Health and Care Excellence (NICE) guidance and physical intervention training standards in the management of at least six incidents. Staff restrained patients using techniques that were not 'provider approved' techniques taught to staff during their training or proportionate to the risk.

- Staff did not keep clear records or follow the Mental Health Act Code of Practice when a patient was placed in seclusion or long-term segregation (LTS). Records of seclusion and long-term segregation were incomplete and unclear. For example, records of the start and termination of long-term segregation were inconsistent. One patient's record showed long-term segregation commenced on four different dates. Nurses did not always complete meaningful seclusion reviews and entries were unclear. Patient reviews frequently stated patients were 'unpredictable' without any explanation or description of the patient's behaviour. Other reviews were contradictory, for example, describing patients as 'settled but unpredictable'. Staff had not ensured that all medical reviews for patients in seclusion or long-term segregation were completed. There were gaps in medical reviews, MDT reviews and reviews by the responsible clinician. Staff had not ensured accurate recording of nutrition and hydration during prolonged seclusion and long-term segregation, and there were no records of items the patient took into seclusion or any record of searches.
- Reintegration plans for patients in long-term segregation were also unclear or absent from patient records. It was not clear from the long-term segregation record or the clinical notes at what stage of reintegration the patient was in and how this was evaluated. Long term segregation and seclusion care plans were standardised and not always updated.
- Staff had completed a tick box stating that the safeguarding team, patient's family and other stakeholders had been notified when a patient was cared for in long term seclusion or segregation. However, there were no corresponding notes, contact names or evidence of sharing this information.
- 90% of the provider's permanent staff were up to date with safeguarding training. However, we found out of the twelve agency staff records which we reviewed, four agency staff (33%) were out of date with their safeguarding training. Staff were able to give examples of abuse, however staff told us not all agency staff knew how to report a safeguarding incident, but they would escalate this to the ward manager who would report this. Managers held monthly safeguarding meetings.
- The hospital was not reporting all abuse or safeguarding allegations to CQC or the local safeguarding authority. Upon reviewing the provider's safeguarding log during our inspection, we found several safeguarding incidents of alleged abuse between patients that had not been reported to CQC. We were also informed by the local safeguarding authority of a patient restraint in which the patient was not happy with the way in which staff restrained them. The provider failed to report this incident to both CQC and the safeguarding team until the patient told the safeguarding team about this incident. We spoke with the local safeguarding authority who told us that the hospital was slow in responding to investigations following safeguarding incidents.
- The hospital had high numbers of incidents, some of which resulted in injuries to both patients and staff. The provider reported 273 incidents at the hospital between 16 November and 13 December 2020, 158 of which were related to violence and aggression. Redgrave ward accounted for the most incidents, 129 incidents in total and 78 relating to violence and aggression.
- The service did not always manage patient safety incidents well. The provider's incident log recorded all incidents which occurred at the service, but staff did not report incidents clearly or as a true reflection of what occurred. Staff did not highlight the severity of the incident or transparently report the actions of staff during the incident. Managers did not fully investigate or review incidents and learning from incidents was not always completed or shared with staff.
- We reviewed CCTV footage of seven safety incidents which had occurred between August and December 2020. The reporting of these incidents was not always clear and incident forms did not accurately reflect the incident as seen on the CCTV footage. Lessons learned were not completed for all incidents and some lessons learned were completed up to two months after the incident and were often very brief. For some of the incidents, no body maps or physical checks for injuries were completed. Managers did not identify appropriate concerns with these incidents in the subsequent incident reviews. For example, there was limited learning identified regarding the use of restraint techniques, the physical health of the patient following restraint or how the incident may be prevented from occurring again.

However:

- 87% of permanent staff were up to date with their infection prevention and control (IPC) training.
- Staff told us that they were offered debrief sessions following incidents, but that these were not formally recorded. Staff told us that individual incidents were discussed during staff handovers and that learning from incidents was usually shared by e-mail or at team training days. We did not see evidence of this, however we saw lessons learned posters which recorded general learning statements such as 'ensure communal areas are manned by staff at all times' and 'staff to ensure that all paperwork is completed following an incident'. The provider told us that they would be establishing monthly lessons learned meetings going forwards.

Are Wards for people with learning disabilities or autism well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- Staff did not always demonstrate the values of the provider. Incidents which we reviewed demonstrated a lack of dignity and some incidents demonstrated elements of abuse towards patients. For example, a staff member was seen to push a patient onto the floor and some staff did not always help patients to stand up from the floor following an incident. Restraint incidents frequently took place in sight of other patients and staff, as staff did not attempt to direct other patients away from the scene.
- Staff reported feeling stressed due to low staffing levels and the level of aggression from patients. Results from the 2020 'Culture of Care Barometer' highlighted that 42% of staff disagreed with the statement 'A positive culture is visible where I work'. This was an increase of 9% from the prior year. Staff also reported that communication, staffing levels and staff training needed improving. Staff reported they did not have the correct staffing for the level of patient acuity at the hospital. However, staff reported feeling valued and respected by leaders and staff were provided with thank you letters.
- The provider held monthly clinical governance meetings in which staff discussed incidents, staffing, infection control and safeguarding incidents. Despite the meeting minutes highlighting issues in all these areas, the provider had not set actions to address all problems. For example, staff were reported to have been sleeping on patient observations, but no action was set to address this. Concerns with the accuracy of seclusion paperwork and mandatory training were raised, yet no action was created to improve this. Therefore, we were concerned that the provider did not have an overarching quality assurance process of issues identified, actions taken in response to the issues and how these issues were monitored.
- The hospital undertook a thematic review into the seclusion of patients on Redgrave ward from January to June 2020, following an increase in instances of patient seclusion. The review highlighted that seclusion occurred during low activity times on the wards and that there had been an increase in seclusion in non-seclusion designated areas. Since this review, the hospital is building an additional long-term segregation suite for patients. We did not see any further evidence of therapeutic initiatives to reduce instances of long-term segregation or seclusion.
- Our findings from the other key question demonstrated that the provider's governance processes were not operating effectively, and that performance and risk was not always managed well. For example, while staff collected data on patient incidents and broke down patient incidents into the type and location of the incident, the results of this analysis were not used to drive quality improvement at the hospital. We found that incident reviews did not highlight key learning which could help to prevent incidents from occurring again and lacked meaningful critical analysis.

Inadequate

Wards for people with learning disabilities or autism

- We were particularly concerned that managers did not take immediate action following an incident review of a patient restraint. The incident in August 2020, in which a patient was pulled to the floor in the prone position, was reviewed by managers a week later however following this, managers did not take any immediate action to address the concerns or manage the patient's risk. We raised concerns about this incident to the provider in December 2020, which has since resulted in staff being suspended from working at the hospital and the provider reporting the incident to the police.
- Risk at the hospital was not always managed well, as patients were exposed to harm due to low staffing levels and inappropriate use of restraint. Patient management plans were not reviewed to check if they were working and managers had not ensured regular audits were undertaken to identify if patient care documents were reviewed against patient progress or presentation. Furthermore, despite the provider challenging staff when not wearing appropriate personal protective equipment (PPE), we saw numerous pieces of CCTV footage in which staff were not wearing masks appropriately and audits of cleaning schedules did not pick up gaps in cleaning or create actions to address issues. We were also not assured that patient complaint processes were overseen or operating effectively as staff were not aware of an informal complaint process or how patient complaints were reviewed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	S31 Urgent variation of a condition 1. The registered provider must not admit any new patients to St Johns House, Lion Road, Palgrave, Diss, Norfolk, IB22 1BA without the prior written agreement of the Care Quality Commission. 2. By 5pm on 29 December 2020, the provider must review its admission criteria for St Johns House against standards for secure services. The provider must provide a report to CQC detailing the findings of the review and any action plan by 5pm on 29 December. 3. By 5pm on 29 December 2020, the registered provider must assess all service users currently at St Johns House against the admission criteria to ensure that they continue to meet the criteria for admission, and they are able to meet the needs of the service users. The provider must provide a report to CQC detailing the findings of the review and any action plan by 5pm on 29 December. 4. The registered provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experience staff required on all wards at all times to provide safe care and treatment of patients based on levels of risk and care needs as identified in conditions 2 and 3 (above). This includes ensuring there are enough staff to implement observation and management of aggression procedures in line with the provider's policies. By 5pm on 29 December 2020, the provider must provide CQC with a copy of the planned staffing for each ward and thereafter on a weekly basis. 5. By 5pm on 23 December 2020, the registered provider must ensure that a review of staffing on each ward at St Johns House is carried out to assure themselves that staff are suitably qualified and competent to carry out their roles in a secure environment and are trained in the identification and management of clinical risk and

Enforcement actions

aggression. The registered provider must supply CQC with a report setting out the results of the review and any actions which will be taken as a result by 5pm on 29 December.

6a). By 5pm on 29 December 2020, the registered provider must undertake a review of all service users risk assessments, nursing assessments, associated care plans and positive behaviour support plans. This review must be undertaken by a suitably qualified, competent, experienced and skilled professional.

b) By 5pm on 29 December 2020, the registered provider must provide the Care Quality Commission with a report to confirm that these reviews have been undertaken and the action taken as a result including details and qualifications of those staff who have been involved in undertaking these reviews. Thereafter, the Registered Provider must provide the Care Quality Commission with a fortnightly report detailing the progress made against the action plan starting by 5pm on Monday 4 January 2021.

7a). By 5pm on 29 December 2020, the registered provider must undertake a review of restraint, seclusion and long term segregation practice to ensure this meets the Mental Health Act Code of Practice and considers the environments in all areas where service users are secluded or segregated. This is to include: assessments of ligature risks within the area and how to ensure service users' privacy and dignity.

b) By 5pm on 29 December 2020, the registered provider must provide the Care Quality Commission with a report detailing the outcome of the practice and environmental review and an action plan which describes the action taken and to be taken with timescales. Thereafter, the Registered Provider must provide the Care Quality Commission with a fortnightly report detailing the progress made against the action plan starting by 5pm on Monday 4 January 2021.

8a). By 5pm on 29 December 2020, the registered provider must implement an effective system for reporting and investigating safety incidents and safeguarding matters. The system must be clear, ensure that all relevant concerns are considered and

Enforcement actions

investigated and also ensure that learning from incidents is used to inform and improve practice. By 5pm on 29 December, the provider must report to the Commission on the system put in place.

b) Commencing from 4 January 2021 and thereafter on a fortnightly basis, the provider must provide the Commission with any monitoring data and audits undertaken to monitor implementation of the system.

9. By 5 pm on 4 January 2021, the registered provider must review and investigate an incident that occurred in August 2020 referenced as '129204'. By 5 pm on 4 January 2021, the provider must provide the Care Quality Commission with a report detailing the outcome of the review and any actions taken including timescales, Thereafter, the Registered Provider must provide the Care Quality Commission with a fortnightly report detailing the progress made against the action plan starting by 5pm on Monday 18 January 2021.