St John's House

Quality Report

St John's House
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Date of inspection visit: 13-14 January 2016
Date of publication: 24/06/2016

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

Overall we rated St John's House as inadequate because:

- There were high incidences of restraint including prone and rapid tranquillisation. On Redgrave ward on four occasions there was no monitoring of rapid tranquillisation. Restraint was not effectively monitored and action taken. The provider had a plan in place to reduce restrictive intervention since 2014 but this had not been effective.
- Some of the wards did not provide a safe and clean environment. Bure had ligature risks that staff had not assessed. Although Walsham and Redgrave wards were clean and well maintained, both Bure and Waveney were dirty.
- Staff did not always monitor the physical health of patients adequately. Staff on Waveney ward did not monitor the physical health of one patient with diabetes regularly. Staff on Redgrave did not change the level of observation or make any other health intervention after one patient had swallowed an item.
- Not all of the staff were up to date with mandatory training some training levels were below 75%. Staff did not receive the appropriate mandatory training necessary for their role. However, an experienced member of staff was present on the ward at all times. The ward manager was able to adjust staffing levels to take account of the patient mix. Staff knew how to recognise and report incidents.
- The seclusion suites did not meet the requirements of the Mental Health Act code of practice. Patients in seclusion on Bure and Waveney could not see natural daylight because ward staff did not know how to operate the electronic blinds. The seclusion suite on Waveney room door had a window that was cloudy and unclean. The Bure ward seclusion room was dirty. The seclusion wet room window area was dirty with mould around the window frames.
- Although the staff had strategies to manage challenging behaviours, one patient on Redgrave ward needed a mechanical restraint plan and did not have one. Patient care records varied in content and detail. Although staff recorded patients life histories particularly those with long and complex histories of care.
- There were blanket restrictions related to access to outside space after 7:15pm. Staff told us this was due to staffing levels.
- One patient needed medicines for a rash and was in discomfort. The medicines were not in stock and staff did not seek to obtain emergency medicines.
- On Bure ward clinic room sharps bins in use were not dated and recorded once in use. There was no signage present regarding the presence of oxygen cylinders on the wards.

However:

- Throughout the inspection we saw patients were treated with kindness, dignity, respect and compassion whilst they received care and treatment. Patients knew where and how to access advocacy services. Staff appeared interested and engaged in providing good quality care to patients. Patients were involved in care planning. There was effective input from the GP with regular visits and chiropody care. Medicines management were generally satisfactory on wards. The records showed that patients were getting their medicines when they needed them.
- Patients had access to a full range of rooms and equipment to support care and treatment including a multifaith room. There was a choice of food to meet the specific dietary requirements of religious and ethnic groups. There was a weekly timetable of community and on-site occupational activities. Staff liaised with outside agencies and groups to ensure patients received an effective discharge.
- Complaints received had been investigated and acted upon quickly, and there were good systems in place to share learning from complaints throughout the hospital. However, there was insufficient accessible information around patients care and treatments.

Summary of findings

- There were regular and effective multidisciplinary meetings and working relationships with teams outside the organisation such as social services. Staff had received an annual appraisal of their work performance and regular managerial supervision. Staff told us there was good team work and staff morale.

Staff knew the senior management team. The lead psychologist was involved in research and development of offence related treatment programmes specific to learning disability. Regular security briefings alerts were circulated to wards with lessons learnt and recommended actions.

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 	St John's House provides wards for people with learning disabilities

Summary of findings

Contents

Inadequate

St John's House

Services we looked at:
Wards for people with learning disabilities or autism.

Summary of this inspection

Background to St John's House

St John's House is an independent hospital providing low and medium secure services for people with learning disabilities, problems with substance misuse and associated mental health needs.

The hospital is registered to provide treatment of disease, disorder or injury, diagnostic and screening procedures and assessment or medical treatment for persons detained under Mental Health Act 1983.

There is a registered manager and an accountable officer.

The hospital provides 49 beds for men and women. At the time of inspection, there were 48 patients receiving care and treatment. All the patients were detained for treatment under the terms of the Mental Health Act (1983).

The hospital has four wards:

- Walsham ward has 16 beds and provides medium secure services for men
- Redgrave ward has 16 beds and provides medium secure services for women
- Bure ward has 11 beds and provides low secure services for women
- Waveney ward has six beds, and provides low secure services for women.

St John's House has been registered with CQC since December 2010. There was one routine inspection in November 2014. The hospital was assessed as compliant. There have been five separate MHA review visits across all wards between 2014 - 2015. Walsham ward had two visits February 2014 and August 2015. The MHA review visits showed physical health checks were carried out upon admission. Patients received regular input from GP services. Responsible clinicians' assessed the patient's capacity to consent to treatment. There was effective discharge planning for patients. Detained patients had access to IMHA. Approved mental health practitioner reports were available. Patients had their rights to dentition explained to them, and access to unit community meetings.

Our inspection team

Our inspection team was led by:

Victoria Green; Inspection Manager mental health.

The team that inspected St John's House consisted of :

- three CQC inspectors
- one Mental Health Act reviewer
- two specialist pharmacists
- one specialist advisor
- one expert by experience. An expert by experience is someone with experience of using services that helps us to make judgements.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of this inspection

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

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

During the inspection visit, the inspection team:

- visited all areas of the hospital, looked at the quality of the environment and observed how staff were caring for patients
- met with 12 patients who were using the service
- spoke with three family members of patients
- spoke with the clinical nurse manager, practice nurse manager, acting director of nursing, medical director and hospital director
- spoke with 26 other staff members, including a consultant psychiatrist, charge nurses, nurses, ward managers and healthcare workers
- interviewed the senior managers of the service and those with lead roles within the team
- attended and observed a staff handover meeting and catch up meeting
- looked at 12 care and treatment records of patients
- carried out a specific check of the medication management
- looked at policies, procedures and other documents relating to the running of the hospital.

What people who use the service say

We spoke to 12 patients and three carers about their experience of the hospital.

There were mixed comments from patients. Patients told us they felt safe at the hospital and that staff were caring and understanding. Four patients told us they were unhappy with the meals. Mealtimes were not flexible, food did not taste good and portions were small. One patient said they were unable to make a hot drink after 11:30pm. Another patient told us they could not access snacks or hot drinks at any time.

Three patients told us section17 leave was regularly cancelled as there were not enough staff. One patient could not attend church regularly. Two patients told us they could not go outside for fresh air after 7:15pm.

One patient complimented staff for providing clear explanations as to why staff restrained and forcibly medicated them. One patient was pleased with the support from the dietician. Another patient praised staff, who regularly helped them to do their makeup and hair.

One carer told us staff understood their relative's specific needs and kept them safe, but had not seen a care plan. Another carer told us there were not enough staff and trips were cancelled. The hospital used 'skype' to communicate with one family about their relative as they lived far away. Staff could see and speak with family members over a call. A relative of a patient told us, their relative had been injured over the Christmas period and staff did not contact the family to notify them of the incident. Staff later told relatives this was because they were short staffed on the day they and had not been able to telephone.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

- There were high incidences of restraint including prone and rapid tranquillisation. On Redgrave ward on four occasions there was no monitoring of rapid tranquillisation. Restraint was not effectively monitored and action taken. The provider had a plan in place to reduce restrictive intervention since 2014 but this had not been effective.
- Bure ward had several ligature points posing a risk to patients. The September 2015 ligature risk assessment did not identify these risks.
- Bure and Waveney wards were not clean and were poorly maintained. The clinic rooms and nurses station were particularly dirty and dusty.
- The seclusion suites did not meet the requirements of the Mental Health Act code of practice. Patients in seclusion on Bure and Waveney could not see natural daylight because ward staff did not know how to operate the electronic blinds. The seclusion suite on Waveney room door had a window that was cloudy and unclean. The Bure ward seclusion room was dirty. The seclusion wet room window area was dirty with mould around the window frames.
- There were blanket restrictions related to access to outside space after 7:15pm. Staff told us this was due to staffing levels.
- Although the staff had strategies to manage challenging behaviours, one patient on Redgrave ward needed a mechanical restraint plan
- Staff were not up to date with mandatory training with low compliance under 75%. Staff did not receive the appropriate mandatory training necessary for their role.
- One patient needed medicines for a rash and was in obvious discomfort. The medicines were not in stock and staff did not seek to obtain emergency medicines.
- On Bure ward clinic room sharps bins in use were not dated and recorded once in use. There was no signage present regarding the presence of oxygen cylinders on the wards.

However:

- Walsham and Redgrave wards were clean and well maintained.
- Medicines management were generally satisfactory on wards. The records showed that patients were getting their medicines when they needed them.

Summary of this inspection

- An experienced member of staff was present on the ward at all times.
- The ward manager was able to adjust staffing levels to take account of the patient mix.
- Staff knew how to recognise and report incidents.

Are services effective?

Requires improvement

- Physical health care monitoring was generally satisfactory but we found some exceptions that needed improvement. Staff on Waveney ward did not monitor the physical health of one patient with diabetes regularly. Staff on Redgrave did not change the level of observation or make any other health intervention after one patient had swallowed an item.
- Staff did not receive the necessary specialist training for their role.
- Patients records varied in content and detail.

However:

- Staff recorded patients life histories particularly those with long and complex histories of care.
- There was effective input from the GP with regular visits and chiropody care.
- There were regular and effective multidisciplinary meetings and working relationships with teams outside the organisation such as social services.
- Staff had received an annual appraisal of their work performance and regular managerial supervision.

Are services caring?

Good

- Patients were treated with kindness, dignity, respect and compassion whilst they received care and treatment.
- Patients knew where and how to access advocacy services.
- Staff appeared interested and engaged in providing good quality care to patients. Patients were involved in care planning.

Are services responsive?

Good

- Patients had access to a full range of rooms and equipment to support care and treatment.
- Patients had access to spiritual support and a multifaith room.
- There was a choice of food to meet the specific dietary requirements of religious and ethnic groups.

Summary of this inspection

- Staff liaised with outside agencies and groups to ensure patients received an effective discharge.
- There was a weekly timetable of community and on-site occupational activities.
- Complaints had been investigated and acted upon quickly and there were good systems in place to share learning from complaints throughout the hospital.

However:

- There was insufficient accessible information around patients care and treatments.

Are services well-led?

Inadequate

- The arrangements to reduce restrictive interventions had not operated effectively with adequate monitoring and action taken.
- Senior managers failed to assess health and safety risks to the premises which impacted on the safety and wellbeing of patients.
- The leadership had not made arrangements to ensure staff received mandatory training.

However

- Staff told us there was good team work and staff morale. Staff knew the senior management team.
- The lead psychologist was involved in research and development of offence related treatment programmes specific to learning disability.
- Regular security briefings alerts were circulated to wards with lessons learnt and recommended actions.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The mental health act administrator and staff had received training around the new Mental Health Act Code of Practice in June 2015. Policies had been updated in line with the revised Code of Practice. Training records confirmed 55% of staff had received mental health act training. This is low attendance with a staff group of 153 as of January 2016. Twenty two nursing staff were out of date with mental health act training. Senior staff told us they planned more mental health act training.
- We checked 12 patients care records and documentation complied with the Mental Health Act.
- Records showed evidence of patients' capacity to make decisions about their treatment had been assessed and their consent to treatment was recorded at the time that treatment began.
- Qualified staff routinely reviewed patients' capacity assessments.
- Patients' rights were explained to them and re-read regularly.
- Patients had information about the Independent Mental Health Advocacy (IMHA) service. Noticeboards on wards displayed information about the MHA and the IMHA service.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that:

- Fifty five per cent of staff completed training in the Mental Capacity Act 1985 (MCA), as part of their staff induction.
- Staff assessed patients' capacity to make decisions about their treatment appropriately in line with the principles of the MCA.
- A Mental Health Act administrator supported patients and staff with guidance around the Mental Capacity Act and Mental Health Act.

Inadequate

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

- Only two of the four wards Walsham ward and Redgrave ward were clean and well maintained. On these wards cleaning records were up to date and demonstrated the environment was regularly cleaned. Bure and Waveney wards were not clean, did not meet infection control standards and poorly maintained. The clinic room and nurses station were particularly dirty and dusty.
- The Bure ward seclusion room was dirty. The seclusion wet room window area was dirty with mould around the window frames. There was no evidence of regular cleaning. Patients in seclusion on Bure and Waveney could not see natural daylight because ward staff did not know how to operate the electronic blinds. This meant patients using seclusion relied on artificial lighting. We told the registered manager and the electronic blinds were later seen in operation during the inspection on both wards. The seclusion suite on Waveney room door had a window that was cloudy and unclean. The seclusion suites did not meet the requirements of the Mental Health Act Code of Practice. Following the inspection managers provided an action plan that showed cleanliness on Bure and Waveney wards had been reviewed.
- There were ligature points identified on Bure ward. Ligature points are fixtures or fittings to which patients intent on self-harm could tie something to harm them. Ligature points were found on wardrobes, windows in bedrooms, on wall mounted paper towel containers and toilet paper dispensers. Although staff completed a ligature risk assessment in September 2015, they did not identify, take action or develop a strategy to mitigate the risk. Ligature cutters were available to staff on wards. Following the inspection managers told us they had reviewed the identified ligature points and made Bure ward safe.
- We saw gardens leading from each ward. They provided a spacious area for patients to be able to access fresh air. The hospital grounds provided a sensory garden with seating, and pond and an area where chickens were kept.
- Staff checked emergency equipment, such as defibrillators and oxygen, regularly to ensure it was fit for purpose and could be used effectively in an emergency. There was no signage to tell staff where the oxygen cylinders were on the wards. Staff also checked emergency medication that was located on Bure ward.
- There was access to appropriate alarms and nurse call systems in patient areas.

Safe staffing

- The hospital was unable to provide definitive lists of total staff working at St John's hospital. This was because most staff worked across another hospital site run by the same provider. Staffing levels varied from ward to ward with eighteen substantive staff on wards for six patients, to 26 staff on a 16 bedded ward. There were 12 hour shift patterns. On the four wards we visited, staff told us that there was generally enough staff on duty to meet the needs of the patients. From the information the hospital provided us, we saw in the a

three month period between August to October 2015 a total of 1902 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies. We noted that 856 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies. This meant that there was a reliance on the use of bank and agency staff and, on some occasions, wards operated short of staff.

- The ward managers told us that they are able to adjust staffing levels daily to take into account increased clinical needs. This included, for example, increased level of observation or patient escort. Some ward managers would cover staff breaks if required. From the information provided by the hospital, we saw the average staff vacancy rate for November 2014 to October 2015 on Waveney ward was 49%, Bure was 30.5 %, Redgrave 20% and Walsham 9.5%. The average staff turn-over rate for the same time period was 5%.
- The staff told us that there was a heavy reliance on the use of bank and agency staff. Staff told us, and the duty rotas we saw confirmed that there was always an experienced member of staff on duty on the ward.
- Duty rotas for week starting 11 January 2016, confirmed that safe staffing levels were being met. A combination of permanent, bank and agency staff were covering the shifts to ensure that the correct number of staff were on duty. Senior managers told us they had contracted out blocks of certain shift patterns to agency staff, to ensure some continuity of care. Senior managers told us agency staff were provided with mandatory training.
- Managers told us that the staffing difficulties arose from a combination of staff sickness, along with staff recruitment and retention. From the information we saw for the period November 2014 to October 2015, the staff sickness average for each ward was 3%-4%.
- Occupational health services were available to staff. Recruitment to vacant positions was ongoing and five newly qualified nurses were due to start in March 2016. More healthcare workers had recently been appointed.
- Three patients told us section17 leave was regularly cancelled because there were not enough staff. Managers and ward staff told us they regarded section 17 leave as a priority and where possible ensured it by using agency staff. Managers told us monthly section 17 leave audits were undertaken monthly but we did not see the audits or improvements made.
- Patients had requested a section 17 leave audit in January 2014. This was conducted over a six week period to identify times when section 17 leave was cancelled and what explanation patients were given. The outcome was from the 449 planned episodes of section 17 leave 15% did not happen. The three main reasons were 49% patients failed a mood check, due to staffing issues 22%, and 14% patients were offered section 17 leave and did not want to go. The audit did not include a completed action plan and was difficult to read. It was not clear if an easy read version was made available to patients. After the inspection managers provided us with current data. Records for October to December 2015 showed that out of 1562 episodes of planned Section 17 leave, 8 were cancelled (0.5%).
- A review of training records showed 38% of staff had completed safeguarding vulnerable adults training. Safeguarding vulnerable children training was not provided. This was because children were not allowed on the hospital site unless as visitors to relatives. On the few occasions where this happened the visit was overseen by trained supervisors from the social work team. Twenty nine nursing staff were out of date with safeguarding training. Forty non-nursing staff had completed safeguarding training. Overall there was low attendance. Following our inspection managers showed us data with improvements in staff training with 77.4% compliance; and plans to roll out safeguarding training for staff and a specific course for managers.
- The hospital offered a wide mandatory training programme. Attendance at mandatory training was overall at less than 75%. Staff mandatory training records showed the following rates of completion:
- Health and safety training 81%
- Immediate life support 63%
- Infection control level 1 62%
- Food hygiene 55%
- Basic life support 51%
- Breakaway training 41%
- Security training 33%
- Infection control level 2 34%
- Suggestions, ideas and complaints training 30%

- The provider had not addressed staff training needs which meant patient's safety was not protected.

Assessing and managing risk to patients and staff

- Staff used short-term assessment of risk and treatability (START) to assess and formulate risk. The process of completing START involves consideration of a patients current mental state, behaviour and to consider their strengths and as well as vulnerabilities. Patients had personalised risk assessments. Staff told us that where particular risks were identified, such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. Overall, the individualised risk assessments we reviewed had taken into account the patient's previous history as well as their current mental state, and were detailed. However, this was not the case on Redgrave ward, where one risk assessment lacked comprehensive details. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, care programme approach (CPA) meetings or after an incident.
- On Redgrave ward one patient's behaviour support plan indicated a potential need for mechanical restraint because of high risks particularly when attending hospital appointments. Mechanical restraint is defined as the use of straps, belts or other equipment to restrict a person's movement. An incident had occurred in 2014 and referred to care plans for more information, but no details were found in the care plans. We found in clinical notes an emergency multidisciplinary team (MDT) meeting decision to use a personal evacuation mattress and body straps and handcuffs. There were no plans for future use. In accordance with the Mental Health Act Code of Practice provision for mechanical restraint should be recorded as a strategy in the positive behaviour plan. This had not been done.
- All four wards provided seclusion facilities. The hospital provided information stating there had been 287 incidents of the use of seclusion between May to November 2015. The majority of these incidents 142 occurred on the Redgrave ward. There had been three incidents of long term segregation in this period. We talked to ward staff about these incidences. Where this happened patients were being closely monitored by the multidisciplinary team.
- There were 1094 incidents of the use of restraint May to November 2015. These incidents occurred across all wards with Redgrave and Bure wards having the higher levels of restraint. There were highest levels of restraint was on Redgrave ward in comparison to the rest of the hospital. Staff explained these related to just a few patients. The restraints involved 39 patients. Out of all the incidents, 320 were prone restraint and 22 resulted in rapid tranquilisation. However, appropriate physical monitoring post rapid tranquilisation on Redgrave ward was not documented on four occasions. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance recommends providers work towards a reduction in the use of prone restraint and that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible.
- While senior managers told us one of their key objectives 2014/15 was to reduce restrictive interventions, the initial data showed restrictive interventions were increasing in 2015. Restrictive interventions are defined as any intervention that is used to restrict the rights or freedom of movement of a person. We were not assured plans in place were effective.
- Some practices were restrictive. Patients and ward staff told us patients were not allowed outside for fresh air after 7:15pm. Staff told us this was due to staff handover tasks. This meant staff routines were given preference over patient's access to fresh air. Senior managers told us this arrangement was being reviewed. Following on our inspection managers told us the service governance committee met in February 2016 to discuss the restrictive practice. It was agreed consideration would be given to ways to increase patient access to outside fresh air in the evenings, based on individual risk assessments. All four wards had been monitored in February and March and a further review due in April.

Following this patients individual risk assessments would be reviewed in May 2016, so that patients can be identified to be allowed access to the outdoor areas and fresh air in the evenings.

- Hot drinks were not available during the day on request. However two patients told us hot drinks were not available after 10.30pm during the week or 11.30pm at weekends. Following on our inspection managers told us hot drinks were available after 10.30pm and this would be facilitated by staff.
- Medicines overall in the hospital were satisfactory. Medicines including those requiring cool storage, were stored appropriately and at the correct temperature, and so would be fit for use. The clinic rooms were well ventilated. Emergency medicines were available for use and these were checked regularly, including oxygen cylinders. There was no signage present regarding the presence of oxygen cylinders on the wards. There was a pharmacy top-up service for stock and other medicines, which were ordered on an individual basis. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their prescribed medicines when they needed them. This included those prescribed between pharmacy visits. There were systems in place for stock checking medication, and for keeping records of medication which had been destroyed or returned to the pharmacy. The sharps bin on Bure ward was not dated and recorded with the first date of use.
- We looked at the prescription and medicine administration records for 18 patients. Appropriate arrangements were in place for recording the administration of medicines. The records showed that patients were getting their medicines when they needed them. If people were allergic to any medicine this was recorded on their medicine prescription card. There were regular weekly audits of medicines carried out by ward managers, and there was one medicine error reported as a serious incident during 2015. Information regarding the error was cascaded to the nursing staff team via e-mail and ward meetings.
- We spoke with one patient who said they were in pain, and looked at their care notes. The patient had received a burn following an incident. Some pain relief was given to the patient, and further physical checks provided by staff. Additional pain relief was prescribed and ordered on Monday and arrived four days later. Staff did not consider the emergency medicine route to obtain the medicine sooner. The manager told us this incident had been reported to the local safeguarding team.
- Some people were prescribed medicines to help them calm down during extreme episodes of agitation and anxiety. This is known as rapid tranquillisation. These medicines were prescribed to be given only when staff had used other calming techniques. However, appropriate physical monitoring after rapid tranquilisation was not always documented on Redgrave ward. Following the inspection senior managers showed us action plans, ward managers gave copies of the rapid tranquilisation policy to all registered nurses' and discussed this in clinical supervision.
- Physical monitoring tests were being completed on patients; annual tests were documented and actioned when required. An audit on the use of high dose antipsychotics was completed in August 2015.

Track record on safety

- There had been two serious incidents recorded in the last 12 months. The incidents involved two sudden unexpected deaths. We examined one serious incident report, and found they were detailed and had action plans about how to implement the learning from the investigation. The second report was still being completed.
- There were regular security briefings alerts circulated to wards around potential risks with lessons learnt and recommended actions around items for example an asthma inhaler that could be used for smoking purposes. The briefings helped staff become aware of risky items when undertaking security checks.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the recording systems. Incident forms included a description of the incident, triggers, actions and staff involved. The clinical nurse manager reviewed all incidents and reported them to the senior management team. This system ensured senior managers were alerted to incidents promptly and could monitor the investigation and respond to these.
- There were daily catch up morning meetings in the conference room. This involved all members of the

multidisciplinary team. Senior staff from another hospital run by the same provider took part via video conferencing. There were discussions around the previous day and night given for all patients. Information was shared around patients' physical health needs, patients in seclusion, improvements, reviewing of risks, difficulties and strengths and staff allocated tasks.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 12 care records. The detail and standard of care plans were variable on wards. On Walsham ward care plans were personalised and detailed. The care plans on Redgrave were not detailed and one person did not have all the required care plans and risk assessments in place to meet their needs. Care plans included physical health, mental health recovery, behaviour and support plans, risk and safety, searches. Staff had carried out multidisciplinary team pre-admission assessments and risk profiles carried out prior to the patient being transferred to the hospital. Care plans were developed from the initial assessment. Care plans were reviewed monthly and more often if needed, for example related to observation levels or patients leave.
- Patients had behaviour support plans. These plans contained triggers and coping strategies and indicators for restrictive interventions. We saw evidence staff acted on them. Details of how restraint would be carried out and any plans for rapid tranquilisation. Risk assessments summarised the risk areas and levels of risk. Most records sampled included a care plan that showed staff how to manage risks. Risk assessments were reviewed monthly. Patients had copies of their risk assessments, care plans and behaviour support plans, however, these were not available as 'easy read' versions. The inspection team were not provided with the 'easy read' behaviour support plans during the inspection.
- Patients physical health needs were identified. Patients told us, and records showed that patients had a physical healthcare check completed by the responsible clinician within 24 hours of admission. Within seven days of their admission the doctor attended to ensure patients' physical healthcare needs were met. Medical staff documented physical health examinations and assessments following the patient's admission to the ward. Ongoing monitoring of physical health problems was usually taking place. However, clinicians told us patients received an annual physical health, but needed an electronic system to indicate when the patients physical check was due, rather than when they became overdue. The same doctor attended the hospital every Monday and knew patients and staff well. A second doctor was nominated as second clinician to cover to ensure consistency of patient care. The doctor was based at a local surgery and given protected time to review patient's electronic notes.
- One patient with diabetes on Waveney ward did not receive the correct monitoring. The patient's records showed their glucose levels had been high since Sept 2015. In September the patient's glucose levels were 9.1 and December were 20.4. Glucose level checks were irregular and blood level monitoring checks had stopped from 14 December 2015. Staff were unable to account for this. Another patient on Redgrave ward had swallowed some items and had attended hospital for urgent treatment. Upon returning to St John's House the patient's observations levels and physical health care monitoring was not adequately reviewed to mitigate risks. This meant patients' care needs were not being met.

Best practice in treatment and care

- Medical and nursing staff informed us that relevant national guidance was followed when providing care and treatment. This included guidance from the National Institute for Health and Care Excellence (NICE) and prescribing guidance.
- Staff assessed patients using the Health of the Nation Outcome Scales (HONOS) to measure the health and social functioning of people with severe mental illness upon admission. This meant clinicians could build up a picture over time of their patients' responses to interventions.

- The psychiatrist provided patients with their medical treatment. The psychologist and assistant psychologist met with patients within the first few days of admission, and thereafter once a week and provided the person with psychology treatment and support and next steps planning. A variety of therapies were available recommended by NICE. Clinicians offered dialectical behaviour therapy. This is a therapy designed to help people change patterns of behaviour that are not helpful, such as self-harm, suicidal thinking, and substance abuse. Staff delivered cognitive analytic therapy a collaborative programme for looking at the way a person thinks, feels and acts, and the events and relationships that underline these experiences often from childhood or earlier in life. The team provided cognitive behavioural therapy based on individual interventions. This is a talking therapy to treat depression and a number of mental disorders. Some patients were offered an eight week therapeutic programme called, ready for change.
- The occupational therapist team promoted patients wellbeing and developed patients' holistic recovery-oriented care plans with patient input. The clinical nurse manager, nursing team, healthcare workers and activity coordinators supported patient care.
- Staff supported patients to access physical health care, including access to specialists when needed. The practice nurse was the lead for physical health care, first aid, and health promotion and infection control. We saw records of physical health screening for smear tests, regular blood tests, and ophthalmology and dentists checks. The service offered smoking cessation and individual sessions with patients. A dietician was employed in 2016 and contributed to patients care plans and provided education for staff. There was good chiropody care.

Skilled staff to deliver care

- Patients had access to a wide variety of clinical skills and experience from the multi disciplinary team (MDT) which included psychologists, occupational therapists, speech and language therapists, social workers, doctors, nurses, healthcare workers and activity coordinators.
- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the wards and provider policies and a period of shadowing existing staff before working alone. Qualified nurses told us about the preceptorship programme. Preceptorship is a period of time in which to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.
- A training co-ordinator had been appointed and was seven weeks in post. Managers told us behaviour support training was available to staff. This was limited to a class size of 12 due to the physical nature of the course. One staff member has been trained as a behaviour support trainer and more staff were due to attend a three week course in January.
- Managers told us they had followed the care certificates standards induction for ten healthcare workers. Some staff had received care certificate assessor training as trainers and mentors. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe, compassionate care.
- Staff told us that bank and agency staff received a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. Senior managers told us agency staff were able to access mandatory training and supervisory support if required.
- Medical staff received clinical supervision and took part in monthly reflective practice meetings, where they were able to reflect on their practice and incidents that had occurred. Following our inspection managers told us 100% of non-nursing staff had received clinical supervision and appraisals. For nursing staff 68% had received clinical supervision and 60% for appraisal. The ward managers and staff also told us informal supervision took place regularly, although this was not documented.
- Staff described receiving support and debriefing from within their team following any serious incidents.
- Staff told us there were regular team meetings and staff felt well supported by their immediate managers and colleagues on the wards. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.

Inadequate

Wards for people with learning disabilities or autism

Multi-disciplinary and inter-agency team work

- We observed multidisciplinary meetings during our inspection and found these enabled staff to share information about patients and review their progress. Different professionals worked together to assess and plan patients' care and treatment.
- Occupational therapists and psychologists worked as part of each team and worked closely with patients. The consultant and medical staff were a regular presence on the wards and were seen working with patients during the inspection. We observed good interaction between the ward staff and medical teams on the wards.
- Multidisciplinary team ward rounds were carried out weekly. Patients could attend. Each patient would be discussed, including their presentation, history, medication, capacity and appointments. Staff were knowledgeable about each patient's risk, care and treatment needs and spoke about patients in a respectful way. Ward round notes indicated the input by each MDT member.
- There were effective working relations with teams outside of the hospital. Senior managers meet regularly with NHS England commissioners, safeguarding teams in social services, the neighbourhood police, and quarterly meetings with village liaison, local counsellors and neighbourhood watch.

Adherence to the MHA and the MHA Code of Practice

- Staff and training records and confirmed fifty five per cent of staff had received training in the Mental Health Act (MHA) and Code of Practice. The training coordinator had arranged further training following on our inspection.
- The use of the MHA was good on wards. Copies of detention papers including those relating to renewals and transfers were on all files. Patients were reminded of their legal status on admission. Staff regularly assessed patient capacity relating to day to day and this was recorded on patient notes. Information provided included the role of the Care Quality Commission and the role of the independent mental health advocate (IMHA). We saw advanced directives and consent forms in records. A poster was displayed information about the role of the IMHA and how to make contact.
- All the correct legal documentation for treatment for mental disorder was not completed accurately. When reviewing patients' medication records on Redgrave ward one out of four T3 certificates did not match the medication listed on the prescription chart. A T3 certificates includes consent to treatment and all drugs prescribed for mental disorders, including as required medication. One T3 forms recorded dosage of antipsychotic were over the limit on the medicine care. We saw the responsible clinician immediately remove the medication from the charts, so it was then in line with what was on the T3. It was unclear if the patient affected had been informed of the error.

Good practice in applying the MCA

- Fifty five per cent of staff had received training in the Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS). The training co-ordinator had arranged further training following on our inspection. Medical staff kept electronic updates to keep them aware of recent legal decisions on the MCA, and any changes. In the last six months there had been no DoLS safeguards applications made to the local authority.
- Managers told us section 61 consent to treatment audits were undertaken. The mental health administrator and ward staff were not aware of any audits taking place to monitor the use of the MCA.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, dignity, respect and support

- We observed staff treated patients with kindness, dignity, respect and compassion whilst they received care and treatment.
- Patients knew where and how to access advocacy services Rethink Mental Illness advocacy service, purchased by the provider. We saw easy read patient information booklets, and posters and information about advocates, displayed on wards. Carers told us they had received a range of written information including advocacy services upon their relative's admission.

Inadequate

Wards for people with learning disabilities or autism

- Staff appeared interested and engaged in providing good quality care to patients. We observed many examples of staff treating patients with care, compassion and communicating effectively. One patient displayed challenging behaviour and staff had a calm unrushed approach and diverted the patient to daily living tasks. We saw a number of activities taking place and good interaction between staff and patients.

The involvement of people in the care they receive

- Patients were invited to the multidisciplinary reviews along with their family where appropriate.
- Patients views were not always recorded in their care plans. On one behaviour support plan showed positive comments by the patient.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. We saw dedicated areas for patients to see their visitors. One carer told us they kept in contact with the hospital on skype as they lived far away from the hospital. Another carer received weekly telephone calls from staff with on updates on their relatives care.
- Detained patients were entitled to see an independent mental health advocate (IMHA). We saw posters around the service telling patients how to contact either general or independent advocates, or staff could contact them. Advocates could be invited to attend CPA meetings, in relation to complaints, solicitor and other situations.
- Patients told us there were weekly house meetings, which patients attended. Meeting notes confirmed varied requests, concerns and suggestions. Action points were allocated to staff to follow up at the next meeting. For example on Redgrave ward, patients had asked for healthy eating snacks each Wednesday and this had been provided.
- Some patients helped the provider to recruit staff and took part in interviewing staff (including senior staff) and assisted staff with staff inductions. One patient had been part of the inspection process and had presented information to the Care Quality Commission (CQC) inspection team.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- There were 48 patients staying at the hospital during our inspection. The average bed occupancy over the last six months was 91%. In the last 12 months there had been four discharges for Redgrave ward, Bure had four, Walsham two and Waveney had none.
- Patients and staff confirmed there was access to a bed upon return from leave.
- A lead social worker had responsibilities for patient discharge and would liaise with relevant community services, and other agencies. Each patient would have care programme approach (CPA) meeting to make clear and specific discharge plans with their families and carers and other professionals. A pre-discharge plan would be drawn up and provided to commissioners. Ongoing support was offered throughout the discharge process and transfer.
- Patients who had successfully worked through their treatment programme may have the opportunity to continue their treatment at Burston House, a step down service near St John's.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms and equipment to support patient's treatment and care. We saw quiet areas on wards where patients could meet visitors and make phone calls in private. We saw on Bure ward the rooms and corridors were narrow and staircase was steep. The range of available quiet areas was limited. The side rooms used were small. This was due to the structure of an older building. Staff told us they working closely as a team to utilise the ward and outdoor areas. However patients were not able to access outside space after

7:15pm. Combined with the building restrictions these aspects impacted on patient's care and wellbeing. Some wards had training kitchens where patients could prepare hot drinks and breakfasts.

- Patients had access to a large grassed communal space and a sensory garden, including a pond and some chickens. Three patients and staff on Walsham ward had cleaned and worked on the pond. Some patients and staff on Walsham ward had laid paving stones, added plants to the sensory garden and installed a bench for patients and their visitors. These resources promoted patients recovery and wellbeing.
- There was access to activities, including at weekends. The hospital provided structured leisure, learning and therapeutic activities. This included a range of activities on and off site such as, cooking, daily walks, rambling, on-site gym, shopping and swimming. Patients were offered daily opportunities to attend to the chickens and work on the hospital grounds. Each patient had an activity timetable. Occupational therapists and activity coordinators planned and provided activities including card making in the activity room and group trips for example to the local animal sanctuary.
- Locked cupboards were available in patients' bedrooms to secure their possessions. Most patients held key to their bedrooms, this was risk assessed. Bedrooms were personalised. There were smoking areas available in ward gardens with wall lighters provided.

Meeting the needs of all people who use the service

- A multifaith room was available to all patients on Walsham ward, and a church service held each month. A chaplain provided regular spiritual support.
- We spoke with 12 patients. Four patients told us they were unhappy with the meals. Mealtimes were not flexible, food did not taste good and portions were small. Staff and patients told us meals were at set times. Another patient told us they could not access snacks or hot drinks outside set times. One patient said they were unable to make a hot drink after 10:30pm. Following on our inspection managers told us hot drinks were available after 10.30pm and this would be facilitated by staff. Water dispensers were available in dining rooms on wards, for use at any time.
- Meals were freshly prepared on site and transported onto the wards. The kitchen provided a choice of food to meet the specific dietary requirements of religious and ethnic groups. A new chef had been recruited. Senior staff told us there had been improvements with a seven week rotating menu, some wards had requested healthy snacks on set days. Each ward had a food comment book of patient's likes and dislikes. A nutrition and weight council forum was due to be been set up. This group would be made up of patients and staff to look at healthy eating. The hospital offered a range of physical activity for patients on site and in the community. New menus were being planned in consultation with the patient council and dietician from April 2016.
- Information was available to patients on the wards and in "easy read" formats a patient information booklet, meetings, activities and events. Patients were provided with copies of their risk assessments, care plans and behaviour support plans, but these were not available as "easy read" versions.
- Upon admission staff would provide patients and their relatives and carers with a recovery folder, with leaflets in "easy read." This included information about recovery, keeping safe in hospital, tell us your ideas and how to complain, the independent advocacy service Rethink, care pathways, social worker and details about the clinical team. The recovery folder was available on wards. Staff were able to access support from interpreters as and when required.

Listening to and learning from concerns and complaints

- Information about the complaints process was available on notice boards around the wards. Patients and their families and carers were provided with an "easy read" complaints leaflet upon admission. This included the hospital complaints lead's name, contact details, and photograph. Patients we spoke with knew how to make a complaint. Staff knew the process and showed patients how to make a complaint. One senior staff member with responsibilities for complaints visited wards regularly to talk to patients and staff about raising complaints and concerns. Each ward held an informal complaint resolution log. There was openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously. Staff received feedback on the outcome of investigation of complaints and acted on findings.

Inadequate

Wards for people with learning disabilities or autism

- Seventy seven complaints were received from 4 January to 29 October 2015. Sixty complaints were upheld, one complaint was partially upheld and eight complaints are awaiting investigation. Thirty two complaints were about Redgrave ward with 21 upheld, 21 were about Walsham ward with 12 upheld, 12 on Bure ward with six upheld, and 11 on Waveney ward with seven upheld. None of the upheld complaints were referred to the independent sector complaints adjudication service or ombudsman.
- Seniors managers told us themes around complaints were related to restraint. Ninety five per cent of complaints received involved patient on patient incidences on the Redgrave ward. Multidisciplinary team meetings were held regularly to discuss ways in which this could be managed. Patients were involved in these plans. One of the hospitals key objectives was to reduce restrictive practices.

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

Inadequate

Vision and values

- Staff told us about the vision and values of the organisation. They were dedicated to the assessment and treatment and care for adults with learning disabilities, and to encourage them to function to the best of their ability. The multidisciplinary team provided a personalised treatment programme to meet the patient's needs. The providers care values were, valuing people, caring safely, integrity, working together and quality.
- Staff knew the management team well and senior managers regularly worked on the ward alongside staff.

Good governance

- The arrangements for governance and performance management did not always operate effectively. Hospital data showed high incidences of restraint including prone and rapid tranquillisation. The restrictive intervention audits had been on-going. Leaders had been slow to respond to issues identified and take action. Although one of the hospital's key targets was the reduction of restraint and seclusion.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way. Not all leaders had the necessary experience knowledge, capacity or ability to lead effectively. There were high incidences of restraint, poor cleanliness and maintenance on two wards, and mandatory training did not meet service targets. Risk management plans were poor, identification of ligature risks posed risks to patients, care plan did not always address potential risks, and two seclusion suites that did not meet the Mental Health Act Code of Practice.
- The approach to service delivery and improvements was reactive and focused on short term issues. Improvements are not always identified or action not always taken. There were blanket restrictions related to access to outside space after 7:15pm. The risk and issues described by staff do not correspond to those reported to and understood by leaders. A low secure inpatient learning disability hospital nearby, run by the same provider had the same blanket restrictions related to outdoor space after 7:15pm. This means restrictions were not routinely risk assessed for each patient.
- A mental health act review on Waveney ward in November 2013 raised reducing the number of restrictive interventions. The provider agreed to audit this aspect and there would be on going review. This meant the hospital were aware for more than two years that restrictive interventions were high. The mental health act review visit in January 2016 on Redgrave ward found 28% of restraint was in prone position and the need to reduce the use of prone restraint. The provider gave us an action plan to reduce the amount of restrictive interventions. The use of prone restraint would be monitored through service management meetings, and service governance meetings, where the intervention data is reviewed and discussed on a regular basis. The mental health act administrator told us they were not aware of any mental health act audits.
- The mental health act review on Redgrave ward in January 2016 also found blanket restrictions around access to fresh air after 7:15pm and access to hot drinks after 10.30pm. The provider responded with an action plan and confirmed there would be a reduction in restrictive practices within the service.

- We saw audits for mattresses, ligatures, medicine management and the use of high dose antipsychotics. Service governance meetings confirmed audits, including progress findings and action plans were discussed monthly.
- The hospital used high levels of agency and bank staff. However, shifts were covered by enough number of staff of the right grades and experience. Staff recruitment was on-going.
- The hospital had been proactive in capturing and responding to patients concerns and complaints. Informal complaint resolution was held with patients at ward level.

Leadership, morale and staff engagement

- We spoke with staff from across the different staff groups. Senior staff told us about integrated teamwork, achievements, and of good leadership that was visible and helpful. Staff told us there was good teamwork on the wards, access to training, and opportunities for leadership development. Staff felt there was an open door policy and managers were approachable. Some staff had worked at the service for several years and knew the patients and staff well.
- Staff considered that morale was good and the service was heading in the right direction.
- Staff knew how to use the whistle-blowing process.
- Most staff we spoke with said they felt well supported by their immediate manager, they felt they could raise concerns and their work valued by them.
- A staff survey was conducted by the provider in 2013 and 2014. Staff scored highest 78% for learning and development opportunities and 75% for quality of service. The lowest score was for personal performance and opportunity 68%. Six of the questions in the survey were used to measure staff engagement. Staff responded to an engagement score of 75% compared to the 69% to the provider score across other services.
- A patient satisfaction survey was sent to patients across the hospital 1Jan to 31 March 2015. The survey was sent to 90 patients including patients from the providers other learning disability services. Fifty six patients completed the survey. Patients were asked seven questions about: their admission, care pathway, meaningful activities, your clinical team, your care and treatment, your rights, family and friends. The outcome of the survey showed some patients care records did not match their ethnicity, not enough activities Monday to Friday, patients not aware of jobs in the hospital, patients wanted to use computers more, not enough known about possible medication side effects. An action plan was drawn up and completed by staff in October 2015. Actions included review of care records to ensure accuracy of personal information, employment of three activity coordinators (but not at St John's House). Posters were displayed around the hospital to advertise job roles for patients, medication and possible side effects at reviews by the responsible clinician. All wards had play stations, and an on-going recruitment to fill hospital vacancies.
- Patients on wards had community meetings and each ward had a patient representative. Some wards had regular meetings and raised issues. Patients on one ward requested more healthy snacks.

Commitment to quality improvement and innovation

- The hospital participated in national service accreditation and peer review schemes for quality network for forensic mental health services. The medium secure units Walsham and Redgrave wards met 88% of the medium secure standards. Patients focus, environment and facilities and physical health care were noted as areas in need of improvements. The low secure units Bure and Waveney wards met 92% of the low secure standards. Workforce, equalities, service environment and recovery areas were noted for improvement. The hospital were working towards these standards.
- The lead psychologist was involved in research and development of offence related treatment programmes specific to learning disability. Following our inspection managers told us that all disciplines at St John's House were involved in research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure action is taken to reduce high incidences of restrictive interventions including prone and rapid tranquillisation.
- The provider must ensure that action is taken to identify ligature risks and to mitigate risk.
- The provider must ensure that action is taken to ensure that premises are kept clean and properly maintained in line with infection control standards.
- The provider must ensure that the seclusion suites meet the requirements of the Mental Health Act Code of Practice.
- The provider must review blanket restrictions related to access to outside space after 7:15 pm.
- The provider must ensure that the mandatory training identified is sufficient to support staff to carry out their role safely and effectively.
- The provider must have an effective governance process, including assurance and auditing systems in place to monitor the care and treatment provided to patients, including incidents of restraint and rapid tranquilisation.

Action the provider SHOULD take to improve

- Ensure that patient care plans address the potential risks to patients.
- Ensure sharps bins are dated and recorded when in use.
- Ensure signage is present regarding the presence of oxygen cylinders on the wards.
- Ensure there is accessible information around patients care and treatments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Bure ward had several ligature points posing a risk to patients. The September 2015 ligature risk assessment did not identify these risks. For example wardrobes, windows in bedrooms and plastic wall mounted paper towel and toilet paper dispensers.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Bure and Waveney wards were not clean and poorly maintained. The clinic rooms and nurses station were particularly dirty and dusty. Two seclusion suites did not meet the requirements of the Mental Health Act code of practice. Patients in seclusion on Bure and Waveney could not see natural daylight because ward staff did not know how to operate the electronic blinds. The seclusion suite on Waveney room door had a window that was cloudy and unclean. The Bure ward seclusion room was dirty. The seclusion wet room window area was dirty with mould around the window frames.

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

This section is primarily information for the provider

Requirement notices

There were blanket restrictions related to access to outside space after 7:15pm. Staff told us this was due to staffing levels.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not up to date with mandatory training with low compliance under 75%. Staff did not receive the necessary specialist training for their role.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The governance process, including assurance and auditing systems to monitor the care and treatment provided to patients, was not robust. There were high incidences of restraint including prone and rapid tranquillisation. On Redgrave ward there was no monitoring of rapid tranquillisation on four occasions. Restraint was not effectively monitored and action taken.