Partnerships in Care Limited

St Johns House

Inspection report

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Date of inspection visit: 20 - 30 April 2021
Date of publication: 09/07/2021

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 effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

This service was placed in special measures in December 2020. Insufficient improvements have been made. The rating from this inspection remained Inadequate and the service has remained in special measures due to the lack of sufficient improvement. The conditions we placed on the hospital's registration in December 2020 remain in place following this inspection.

St Johns House provides care and treatment for patients with a primary diagnosis of a learning disability and associated mental health problems.

We rated St Johns House inadequate because:

- Staff were placing patients at risk of harm by not completing patient observations safely or in line with patient care plans or national guidance. Staff were completing continuous patient observations for up to 10 hours at a time, despite the providers policy stating this should only occur for a maximum of two hours continuously. We found in two out of three checks we undertook, staff were asleep whilst they were meant to be undertaking patient observations. For one patient who had three staff observing them, all three staff were seen to be asleep at the same time. We checked written observation records for the same period, and we found that the staff who were asleep had written observation entries correlating with the times that they were asleep.
- The service did not always have enough nursing and support staff to keep patients safe. Despite an initial improvement in staffing levels since the December 2020 inspection, staffing levels remained inconsistent and during May 2020 there were significant staffing challenges resulting in the manager adjusting patient clinical observation levels to meet staff availability. The service had high rates of agency staff and staffing levels for each day were unpredictable. Nurses were often replaced with healthcare workers. Ward managers and activities staff had to regularly cover gaps in staffing levels.
- Managers had not ensured that agency staff had the right skills or experience to meet the needs of patients in their care. Agency staff lacked mandatory training and not all agency staff were provided with an induction. Managers did not support staff through regular, constructive clinical supervision of their work. Supervision figures ranged from four per cent in January to 19% in March 2021 despite the provider's policy stating this should occur monthly.
- Patients did not have regular access to individual time with named staff as this was affected by low staff numbers on the ward. Staff told us that by taking a patient on leave for an activity, this left staffing too low on the ward. Psychological or therapeutic sessions and patient activities were sparse, and we found that some patients were only offered one or no activities per week. We saw one patient who was waiting four months for a follow up appointment following an initial psychological assessment. We saw a lack of speech and language assessments and staff told us they felt under-resourced and that they did not have time to update care plans in relation to such needs. Managers informed us of gaps in therapy posts over a four-year period.
- Patient risk assessments were not always reviewed after every incident and where reviewed we found that risk assessments were not an accurate reflection of patient risk. Documentation between patient risk assessments and care plan was inconsistent. When risk assessments had been updated following incidents, staff had not specified how they could prevent or reduce the likelihood of the incident occurring again. Staff did not always act to prevent or reduce risks to patients and did not always respond to any changes in risks to, or posed by, patients. We saw two incidents involving patient self-harm where staff did not intervene in a timely manner, with one incident resulting in injury to the patient's head. Risks to patient's physical health were also not always acted upon, for example, when patients' physical observations were beyond their normal range, this had not always been escalated or monitored.
- Managers did not investigate all serious incidents and those that were investigated, did not identify appropriate learning or follow duty of candour processes. Where learning had been identified, this had not been shared with staff

in a timely way. Recommendations from reviews were not always implemented and there was no oversight or monitoring to check if they had been. We found that not all lower graded incidents had a management review within two to seven days of reporting in line with the providers policy. When managers did review lower graded incidents, this was often very brief and included no evidence of how they assessed if the incident was managed in line with the patients care plan.

- When a patient was placed in seclusion or long-term segregation (LTS), staff did not always keep clear records that followed the Mental Health Act Code of Practice. Documentation was not always clear as to where a patient was secluded, and we observed that staff were not always recording a patient's seclusion in a timely manner. Patient care plans did not indicate risks within the areas of seclusion or LTS or how they would be managed. Patient positive behavioural support (PBS) plans did not always reflect that the patient was in LTS, medical reviews were not always completed and over half of the daily LTS records were not recording food and fluid intake.
- Staff developed care plans for each patient, however these did not always meet their mental health, individual or physical needs. Care plans were complicated, overly detailed, appeared to have been copied and pasted across patients and did not describe all patient's physical health conditions or detail a plan of how to safely manage all patient needs. Communication and religious needs were also not clearly documented and there was a lack of planned care for asthma, incontinence and for the side effects of specific medications and dietary needs.
- Staff did not always manage patients in line with their care plans. Staff roles and responsibilities were not clear for supporting patient's physical health needs and information on such needs was not shared effectively between physical health staff and ward staff. Staff did not escalate signs of clinical deterioration in patient health, such as a high pulse, or compete further physical monitoring in response. It was not clear who had oversight of these processes or a plan of action to resolve them. Positive behaviour support (PBS) plans were not regularly reviewed and ward-based activities often failed to link directly to the goals and care needs on individual plans. PBS plans also lacked clear information for staff to provide appropriate care and support to patients.
- Patients were offered a copy of their care plan however some patients who we spoke with reported they did not have up to date copies of their care plans, with one patient's copy dated from 2019. Despite patients and carers having opportunities to feedback about the service through community meetings and surveys, it was not clear how patient and carer feedback was being used to drive quality improvement at the hospital.
- Multidisciplinary team (MDT) meetings did not always ensure all patient risk factors and care needs were discussed or appropriate action was taken. For example, staff did not review a patient's epilepsy care plan during their MDT meeting despite this being a current prominent risk and patient observation levels were not always reviewed during MDT meetings, nor was patients understanding of their observation levels checked.
- Staff did not always assess and record patient's capacity. We checked 14 patient records, and nine records did not have any evidence of a capacity assessment. For patients in seclusion we also found that two patients did not have an updated capacity and consent assessment form when a new medication was added.
- Patients privacy and dignity was not always managed appropriately. Staff told us that there were often too few female staff on duty to care for female patients, meaning male staff provided personal care whilst on female patient observations on occasion. Patients told us that while most staff were kind and caring some staff would speak in a different language in front of them which made them feel uncomfortable and frustrated and that night staff were not fully aware of their risks or actions required to manage their risks. Generally, patient incidents had been managed sensitively however staff did not always direct other patients away from the incident when they had the opportunity to do so, resulting in other patients watching a patient being restrained. Patients were often secluded in side rooms along the corridor of the ward which were not suitable due to the environment and the ability for other patients to observe into the room.
- Prior to our previous inspection the hospital's admission criteria had not been clear which meant that it had admitted patients with acute complex and challenging conditions. Since, the clinical team had completed a review of all patient's suitability against the hospitals admission criteria and identified many patients where an alternative provision was required to ensure their needs were being met. Despite the providers strong efforts to re-locate patients who required an alternative provision, many patients had not been able to move on from St Johns House

Summary of findings

therefore acuity at the hospital remained very high. Despite hospital plans to discharge and transfer patients where appropriate, patient documentation including clinical notes and care plans were not kept up to date with this information and we were not assured that these plans were fully communicated to patients. The average length of stay for patients at the hospital was 2.7 years, however patient stays ranged from 5 months to 9 years 7 months.

- Since July 2020, there had been no registered manager. A total of four temporary managers had covered this role since that time which has resulted in a lack of clear leadership of the service as each manager has needed to develop their knowledge of the service. In addition, due to the hospitals vacant position of medical director, we were not assured that there was suitable oversight of aspects of mental and physical health. We found a lack of oversight for physical health monitoring and it was not clear how medical governance processes were being monitored.
- Our findings demonstrated that governance processes were not yet operating effectively. Managers had developed new ways of working and processes to improve the service, but these were not yet fully embedded or effective. Managers had not yet fully embedded quality assurance processes, such as regular audits of the service, to assess, monitor and improve the quality and safety of the hospital. The service did not complete physical health audits and had not completed other scheduled audits.
- The provider did have a risk management process and improvement plan in place to assess and monitor risk and we noted that the providers improvement plan included most concerns found at this inspection, however sufficient action had not been undertaken to address these issues and risk at the hospital was not always managed well, as patients continued to be exposed to harm due to low staffing levels and poor practice as outlined in this report.
- Not all staff knew and understood the provider's vision and values and staff felt that communication of key decisions between managers and staff could be improved. Many staff felt stressed and reported concerns about under staffing which impacted staff morale and staff did not feel that managers addressed racist abuse towards staff from patients. There was no equality and diversity lead at the service.

However:

- Ward areas were clean and well maintained and staff adherence to infection prevention control (IPC) measures had improved since our last inspection.
- Clinic rooms were clean and fully equipped with emergency drugs that staff checked regularly, and audits picked up on any missing items.
- Permanent staff employed by Priory Group had completed and kept up to date with their mandatory training.
- The hospital conducted an external review of restraint incidents to identify if physical restraint was necessary, proportionate and that provider approved techniques were used. The review was conducted by a specialist nurse who was a lead in restraint techniques. The review shared areas for improvement with staff to improve their management of such situations.
- For patients in long term segregation, daily access to activities and access to fresh air had improved since the last inspection.
- Staff worked with other agencies to report safeguarding alerts and took part in safeguarding meetings with the local authority.
- We did not find the quality concerns with care plans and patient documentation on Bure ward as care plans were specific and person-centred.
- In most interactions we observed, staff treated patients with compassion and kindness. Patients were supported with daily living tasks.
- Staff helped patients to stay in contact with families and carers. Staff facilitated visits from patients' children and supported patients to attend family events.
- Staff made sure patients could access information on treatment, local services, their rights and how to complain.
- Staff spoke highly of the operational manager who had been overseeing St Johns House since January 2021, as they felt she was committed to improving the hospital and was visible on wards.

Summary of findings

- Staff felt supported with COVID-19 related matters such as access to testing, vaccination and personal protective equipment.
- Staff reported positive team working with one another and we observed effective team coordination in relation to a restraint incident on the ward.

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 procedures

The hospital had 49 beds across four wards. At the time of inspection 35 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 12 patients on this ward.
- Walsham ward which was a 16-bed medium secure male ward. There were 12 patients on this ward.
- Bure ward which was a 11-bed low secure female ward. There were five patients on this ward.
- Waveney ward which was a six-bed low secure female ward. There were six patients on this ward.

The service does not currently have a registered manager and the previous registered manager of the service had been absent from the hospital since July 2020, with temporary managers covering this role.

Following a risk based focused inspection in December 2020, the hospital was rated as inadequate overall and within the domains of Safe and Well-led. The December 2020 inspection found the hospital was in breach of Regulations 10, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the CQC (Registration) Regulations 2009. We also suspended the ratings of the Effective, Caring and Responsive domains and placed the service in special measures. Based on the seriousness of our findings, we issued the provider with an urgent Notice of Decision imposing conditions on the providers registration at this location including preventing the provider from admitting further patients to the hospital.

The purpose of this inspection was to rate the service within the domains of Effective, Caring and Responsive, which we suspended in March 2021 and to review the providers progress against the previous breaches of regulations, within the Safe and Well-led domains that we found in our previous inspection.

What people who use the service say

We spoke with 15 patients and three carers during this inspection. Six out of 15 patients told us that they did not feel safe at the hospital and one patient described feeling bullied by other patients. Five patients felt engaged with activities at the hospital although other patients felt there was not enough to do especially at weekends. Two female patients raised concerns of a lack of female staff at the hospital, especially when completing patient observations. However, most patients reported that staff were respectful and polite, with the exception of two patients who described staff using foul language and staff speaking in other languages in front of them.

Summary of this inspection

Feedback from carers of patients was mixed. Two out of three carers said staff were polite, but one carer said staff were rude. One carer was particularly concerned at how understaffed the hospital was and that staff were not always able to maintain patient observation levels due to this. Two carers felt involved in the care of their loved one, although one carer reported this was inconsistent and felt that complaints were 'pushed under the carpet'.

How we carried out this inspection

How we carried out the inspection

The purpose of this inspection was to rate the service within the domains of Effective, Caring and Responsive, which we suspended in March 2021 and to review the provider's progress against the previous breaches of regulations, within the Safe and Well-led domains that we found in our previous inspection.

During the inspection, the team:

- spoke with 15 patients who were using the service
- spoke with two temporary managers of the service and other senior managers at the hospital
- spoke with 28 additional staff from a variety of roles including ward managers, nurses, consultants, healthcare assistants, social workers, activity and therapeutic staff, the workforce coordinator, administration staff, and staff responsible for providing restraint training
- spoke with relevant stakeholders such as the patient advocacy service
- looked at 17 care and treatment records of patients
- looked at 20 seclusion and 20 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
- observed wards, staff meetings and MDT meetings
- and looked at a range of policies, procedures, meeting minutes, hospital data and other documents relating to the running of the service.

Areas for improvement

At our previous inspection of this location in December 2020, we identified breaches in five regulations from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the CQC (Registration) Regulations 2009 which required the provider to take 24 required actions to meet with their legal obligations.

Following this inspection, we found the provider had not taken action to comply with all previous requirements, despite progress in some areas. In addition, we have made 23 new requirements in relation to breaches from ten regulations from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the service MUST take to improve:

Summary of this inspection

- The provider must ensure that staff are aware of the location of emergency equipment such as ligature cutters and the defibrillator (Reg 12(2){e})
- The provider must ensure that patient care plans and risk assessments detail how to individually manage environmental ligature risks (Reg 12(2){a})
- The provider must ensure that staff respond appropriately to patient's physical health needs and physical observations which are beyond their normal range (Reg 9(3){a-b})
- The provider must ensure that staff accurately document patients physical health risks, complete physical health audits and ensure there are clear staff roles and responsibilities for supporting patients physical health needs (Reg 12(2){a-c})
- The provider must ensure that staff respond appropriately to patient self-harm incidents to reduce risk of injury to patients (Reg 12(2){a-c})
- The provider must ensure that patient's Personal Emergency Evacuation Plans (PEEPs) are updated with current patient risks (Reg 12(2){a-b})
- The provider must ensure they record all instances of patient seclusion in a timely way including when this occurs in non-designated areas (Reg 13(4){b})
- The provider must follow and consider the duty of candour following serious incidents to ensure transparency and openness with patients (Reg 20)
- The provider must ensure that patient access to Section 17 leave is safely completed in line with patient care plans and risk assessments (Reg 12(2){b})
- The provider must ensure that patient communication needs are assessed and met for patients who require additional support with communication difficulties (Reg 9(3){b})
- The provider must ensure that patients have access to their care plans and associated documentation in a format that is easy to understand and meets their communication needs (Reg 9(3){g})
- The provider must ensure that patients are aware and involved within their discharge plans (Reg 9(3){a-d})
- The provider must ensure that patients dietary needs are assessed and met and that patients have regular access to specialist care for nutrition (Reg 14(1))
- The provider must ensure that actions which have been identified from incident reviews are monitored and completed (Reg 17 (2){a}{b})
- The provider must ensure staff are provided with regular clinical supervision of their work (Reg 18(2){a})
- The provider must ensure that multidisciplinary team meetings explore all patient risk factors, care needs and that actions from these meetings are monitored and taken forward (Reg 9(3){a-b})
- The provider must ensure that all patients are offered contact with an independent advocate (Reg 9(3){c})
- The provider must ensure that staff assess and record patient's capacity and that this is updated at regular and appropriate intervals (Reg 11(1))
- The provider must ensure patients religious and/or spiritual needs are assessed and met (Reg 9 (1){a-c})
- The provider must ensure that complaints are handled within designated time frames and that all areas are fully investigated prior to responding (Reg 16(1-2))
- The provider must ensure the hospital has an appropriately skilled and appointable Registered Manager (Reg 7)
- The provider must ensure the hospital has adequate medical governance and oversight of mental and physical healthcare (Reg 17(2){a-b})
- The provider must ensure that actions and improvement suggestions from patient community meetings and carer surveys are considered, monitored, implemented if appropriate and feedback is provided to patients (Reg 17(2){e-f})

Requirements made following the previous inspection that the provider must meet:

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- The provider must ensure they have enough nursing and support staff of an appropriate skill and gender mix to keep patients safe, to carry out physical interventions safely, to meet patient observations levels and to offer patients activities and therapeutic interventions (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 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 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 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 all 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 that all safety 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 in a timely manner and changes are made as a result of the learning (Reg 17(2){b})
- 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 and processes in place to identify areas of concern and/or risk, and to identify when policies are not being followed (Reg 17 (2){a-f})

Action the service SHOULD take to improve:

Action a service 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, to prevent it failing to comply with legal requirements in future, or to improve services.

- The service should ensure good attendance from staff at key ward meetings to ensure key information is shared.
- The service should ensure cleaning provision over weekends, as well as during weekdays.
- The service should ensure that issues identified on the service's Infection Prevention Control audit are taken forward, including staff awareness of hand washing and wearing watches or clothing that is bare below the elbow.
- The service should ensure that patient incidents are recorded in the patient's clinical notes, in addition to the providers incident reporting system and patient care plans.
- The service should ensure that patients hospital passports hold accurate and up to date information to safely support patients.

Summary of this inspection

- The service should consider the noisy environment on the wards in relation to the effectiveness of ward based therapeutic interventions, particularly for patients with autism.

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	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate because:

Safe and clean care environments

Safety of the ward layout

- Staff completed and regularly updated risk assessments and audits of all ward areas. However, not all identified ligature risks had been removed or reduced. Mitigation for ligature risks was to manage each risk in line with individual patient care plans and risk assessments. However, when we looked at patient care plans and risk assessments, staff had not specified this, even for patients with a risk of self-harm.
- Some of the wards had blind spots but these were mitigated by enhanced staffing observations and the placement of convex mirrors.
- The ward complied with guidance on mixed sex accommodation.
- Staff had easy access to alarms. However, we found a patient's room assistance alarm was faulty resulting in the patient being unable to call for nurse assistance. This was reported to the provider who repaired the alarm.

Maintenance, cleanliness and infection control

- Ward areas were clean and well maintained. However, some wards may have benefited from updated furniture and re-decorating. The provider had detailed refurbishment needs for each ward on an action plan.
- Staff completed maintenance logs and cleaning records, however cleaning on weekends was sparse. Staff had implemented additional cleaning of high use areas such as door handles and work surfaces which was an improvement since our last inspection in December 2020.
- Staff adherence to infection prevention control (IPC) measures had improved since our last inspection. Staff were seen to be wearing personal protective equipment (PPE) appropriately, we saw signs for hand washing guidance and designated numbers of people allowed in rooms. Staff completed an IPC audit and an IPC action plan was in place including a recent hand washing audit. 93% of staff had completed IPC online training and COVID-19 guidance was available to support staff in managing testing requirements and what action to take for suspected or confirmed COVID-19 cases. However, staff were not always wearing clothing which was bare below the elbow and some staff were wearing watches, although these issues were picked up on the provider's IPC audit. Staff were failing the hand washing

audit and despite staff completing lateral flow tests for COVID-19, we found the extraction liquid had been decanted into the testing tubes for an extended period of time prior to staff completing the tests which could provide false results. The maximum time the liquid should be used once opened is 30 minutes. We raised this with the provider who told us they would stop this immediately.

Seclusion room

- The seclusion rooms allowed clear observation and two-way communication. The toilet for the seclusion room on Redgrave was dirty. Since our last inspection, the provider had built an additional long-term segregation suite which managers told us would be used to seclude patients.
- Due to high instances of seclusion, patients were often secluded in side rooms along the corridor of the ward. The provider had addressed some concerns about potential ligature points in these rooms however the environment was not entirely suitable for seclusion as screws in the door and window were not always countersunk and other patients on the ward can see through the window. The side rooms used for seclusion, for example, the quiet room on Redgrave ward, had no en-suite facilities and patients had to be moved through communal areas to use the toilet facilities. This had been raised as our previous inspection and we remain concerned that these facilities could be used for seclusion or segregation for long periods of time.

Clinic room and equipment

- Clinic rooms were clean and fully equipped with emergency drugs that staff checked regularly, and audits picked up on any missing items. At the previous inspection we had been concerned about the provision of emergency equipment. This had been addressed however, staff did not always know the location of emergency equipment such as ligature cutters and the defibrillator.

Safe staffing

Nursing staff

- The service did not always have enough nursing and support staff to keep patient safe. Despite an initial improvement in staffing levels since the December 2020 inspection, staffing rotas between 26 April 2021 and 2 May 2021 evidenced serious shortfalls in staffing levels, resulting in staff not being able to complete patient observations as prescribed in patient care plans or in line with the providers policy. During this week the hospital was short five staff during a night shift and nine staff during a day shift. Staff told us of low staffing levels on a regular basis and we saw staff were not provided with breaks at times.
- Staff were completing continuous patient observations for up to 10 hours at a time, changing between patients, despite the providers policy stating this should only occur for a maximum of 2 hours. This poses a significant risk to patients and staff due to the difficulty in maintaining concentration and efficiency levels for enhanced support over extended periods of time.
- Vacancy rates for healthcare workers were 20% and 16% for registered nurses. The service had a recruitment and retention plan in place for staff which included incentives for staff, various marketing campaigns, reaching out to varies agencies and encouraging agency staff to become permanent. Unfortunately, the providers recruitment efforts had not yet resulted in a stable workforce.
- The service had high rates of bank and agency staff, 43% of shifts were covered by agency staff. Mangers had appointed into a workforce coordinator role since our last inspection and this individual worked to use agency staff to fill staffing gaps. However, the organisation of staffing rotas and agency staff remained very disorganised and impacted on safe staffing levels. We were told that agency staff who were booked would often not turn up for shift, conversely other

agency staff who were not planned for the shift, would turn up to work. This meant that the provider was not assured on a day to day basis of their overall staffing arrangements. Nurses were often replaced with healthcare workers. Although we were told that agency staff familiar with the service were requested, we were not assured that this was always the case given the finding that some agency staff would turn up to work at the hospital without pre-booking. Ward managers and activities staff had to regularly cover gaps in staffing levels. Staff moved between wards to cover shortfalls on individual wards.

- Patients and staff told us that there were often too few female staff on duty to care for female patients, particularly at night time. Despite ward managers moving female staff to the female wards, patients reported that only male staff were available on two occasions which they said made them feel uncomfortable, for example when male staff provided personal care whilst on their constant observations.
- Managers had not ensured that all agency staff had completed their mandatory training such as safeguarding, first aid, basic life support, breakaway techniques and their patient observation competencies. Agency training compliance was not monitored by the hospital, despite the high percentage of shifts covered by agency staff. Managers had created a new induction checklist for agency staff however they had not ensured that all agency staff had completed this prior to working at the hospital. Staff reported feeling uncomfortable working with some agency staff, due to their lack of experience and inability to handle safety incidents.
- Patients did not have regular access to 1:1 time with staff as this was affected by low staff numbers on the ward. Staff told us that by taking a patient on leave for an activity, this left staffing too low on the ward and resulted in limited engagement with other patients left on the ward. Staff prioritised patient observations and responding to patient incidents including those that required physical intervention, medical visits and family visits which left other activities sparse.
- Levels of sickness were 9% for permanent staff between January and April 2021, which was a reduction of 5% compared to the prior year.

Medical staff

- The service's on-site medical cover was stretched as two consultants covered four wards. There was an on-call system in place for medical cover and the hospital received regular visits from a GP surgery. The hospital was struggling to recruit a third consultant, however the hospital received support from an interim medical director from a separate Priory service. A new medical director had been appointed but had not yet taken up their role. Two practice nurses were also employed by the hospital.

Mandatory training

- Permanent staff employed by the provider had completed and kept up to date with their mandatory training. Overall, 88% of staff were in date with their training, however compliance with immediate life support training was lower at 67%, although following this inspection the provider confirmed that 88% of staff were now provided with immediate life support training due to attending the training in May 2021.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed risk assessments for each patient on admission. However, risk assessments were not always reviewed after every incident and although staff reviewed risk assessments regularly, we found that risk assessments were not an accurate reflection of patient risk. For example, one patients risk assessment did not detail the correct level of enhanced observations and another patients risk assessment increased a patient's risk score despite evidence that their risk in this area had decreased.

Management of patient risk

- Staff did not always act to prevent or reduce risks to patients and did not always respond to any changes in risks to, or posed by, patients. For example, when patients' physical observations were beyond their normal range, this had not always been escalated or monitored further by staff. When risk assessments had been updated following incidents, staff had not specified how they could prevent or reduce the likelihood of the incident occurring again.
- It was not clear from all patient risk assessments how to manage all risks to the patient and there was lack of information on the use of PRN (as required) medication in relation to patient risks. As patient risk assessments were not updated after every incident, we found for example that an increased risk of sexual assault had not been flagged, leaving staff unaware of this increased risk and how to effectively manage it.
- Documentation of physical health risks between patient risk assessments and care plans was inconsistent. We found a patient who was recorded as having a risk of choking, however their care plan encouraged having a meal or drink with other patients. Another patient's physical health risks of heart disease were not documented as a risk on the patient's risk assessment.
- Staff did not act to reduce risk of injury to patients, as we saw two incidents involving patient self-harm in which staff did not intervene in a timely manner, and one of the incidents resulted in an injury to the patient's head.
- Staff had not updated patient Personal Emergency Evacuation Plans (PEEPs) with up to date patient risks, such as the risk of falls and staff were not aware of information in these plans. Out of the seven PEEPS we reviewed, all were out of date and some had not been updated since 2019.
- Staff were not completing patient observations safely or in line with patient care plans or the providers policy. We found in two out of three checks, staff were asleep whilst allocated to patient observations. For one patient who had three staff meant to be observing them, all three staff were seen to be asleep at the same time. We checked written observation records for the period of time that the staff were asleep, and we found that the staff had written observation entries correlating with the times that they were asleep. We also found that a patient with a risk of self-harming, was not receiving four times hourly observations as per their care plan. These practices pose a significant risk to patients and staff.
- Staff were found to be completing patient observations for up to 10 hours without a break. The duration of continuous observations without regular breaks was in excess of the two hours recommended by the National Institute for Health and Care Excellence NG:10 Violence and aggression: short-term management in mental health, health and community settings guidance and the provider's own policy. This meant that the quality of the care provided to patients was at risk, because staff were not taking regular breaks.

Use of restrictive interventions

- The hospital held reducing restrictive practice meetings and staff identified what blanket restrictions were in place on wards. However, staff did not provide specific rationales for all blanket restrictions in place and it was not clear how these were reviewed. Staff reported that the process required more ownership.
- Levels of seclusion were high, and the provider was not able to tell us how often patients had been secluded in non-designated seclusion areas. Levels of seclusion in January 2021 were 22, 23 in February and 21 in March. We were concerned that staff were not always reporting and identifying instances of seclusion in non-designated areas as we

saw a patient secluded on the ward during the morning of our inspection. When we checked the patients records at the end of the day to ensure this had been recorded as seclusion, staff had not recorded this. We raised this with the provider who told us they would ensure this had been documented, however our concerns remain that all appropriate safeguards may not be adhered to if staff are not identifying when they are secluding patients.

- Physical restraint incidents were high, with 107 reported uses of restraint in January 2021, 122 in February and 104 in March, with Redgrave ward demonstrating the highest uses of restraint. This is an increase in the use of physical restraint since our last inspection in December 2020. However, there had been no instances of prone restraint between January and March 2021, which was an improvement since our last inspection.
- Staff were using provider approved restraint techniques and 90% of permanent staff were trained in the use of physical restraint. This was an improvement since our last inspection. However, not all agency staff were trained in physical restraint or breakaway techniques and staff reported feeling uncomfortable when working with agency staff in the event of using physical restraint on patients.
- Staff used de-escalation techniques to support patients prior to using restraint although we saw an inconsistent approach between the use of restraint and staff not intervening soon enough. We observed restraint incidents in which staff missed opportunities to step away from the incident before they used restraint techniques, however we also observed patients who had caused injury to themselves from self-harm due to staff not physically intervening soon enough.
- The hospital conducted an external review of restraint incidents to identify if physical restraint was necessary, proportionate and that provider approved techniques were used. The review was conducted by a specialist nurse who was a restraint techniques lead. The review shared areas for improvement for staff to improve their management of such situations, as well as highlighting good practice. We saw these learning points shared to staff via bulletins.
- When a patient was placed in seclusion, staff did not always keep clear records that followed the Mental Health Act Code of Practice. We reviewed 20 seclusion records from all four wards at the hospital. We found that four patients were secluded in non-designated areas and it was not always clear where the patient was secluded. Patient care plans did not indicate risks within the areas used for seclusion, or how they would be managed. Records did not detail how the patient should be observed or enabled to use the toilet.
- Staff had not always completed care plans for instances of seclusion which lasted longer than one hour, and the quality of seclusion care plans was inconsistent. Some recorded appropriate risks but did not detail how the risk would be managed. Most food and fluid sections were also incomplete, despite care plans indicating that patients would be provided with food and fluids during seclusion.
- Staff had not ensured medical reviews were completed when a patient was secluded. Six out 20 records showed that a doctor did not attend within the first hour of seclusion. In one record the seclusion was during the weekend and in five records the seclusion commenced outside of office hours. Seven records showed the nurse who initiated seclusion also carried out the first nursing review, one review was carried out by one nurse only and another review had not been signed or timed by the second nurse.
- In 10 out of 20 seclusion records, staff had not always ensured that family members, carers or advocates had been informed of a patient's seclusion.
- None of the 20 records indicated whether the patient had been searched prior to seclusion or if they took anything into the seclusion room. This is in breach of the provider's policy.
- However, most of the seclusion records indicated that seclusion was terminated at the earliest opportunity and there was clear description of the incident leading to the seclusion including interventions used to de-escalate the situation. Staff offered a de-brief session to patients and one patient wrote their own debrief. There was improvement from our last inspection in clear descriptions of patient's behaviour, mood and engagement with staff during seclusion.
- Staff did not always follow best practice guidance when placing a patient in long term segregation (LTS), including adherence to the Mental Health Act Code of Practice. We reviewed 20 LTS records, for three different patients. Records

were not always clear where the LTS was taking place and staff had not ensured that patient positive behavioural support plans always reflected that patients were in LTS. They did not reflect the triggers associated with long-term segregation and how these were to be reduced and only one patient in LTS had a reintegration programme with clear goals/stages.

- Over half of the daily LTS records for each of the three patients had a blank or partially completed food and fluid chart. There were records in observation notes of snacks, drinks and meals given but this was inconsistent and there was no detail as to what the patients' needs were, despite one patient being categorised as extremely obese.
- Staff had not ensured medical reviews were completed when a patient was placed in LTS. Patients were not reviewed daily by an approved clinician. Nursing records noted that the multidisciplinary team had reviewed the patient, however there were no notes of who was involved or what was discussed.
- Two patients in LTS did not have records of contact with independent mental health advocates (IMHA) and there was no evidence of IMHA or commissioner input into the LTS reviews.
- However, each LTS record included a clear rationale for why the patient was in LTS, patients had regular telephone contact with their families, access to therapeutic sessions, daily access to activities and access to fresh air. We saw improvements from our last inspection in observations records which included descriptions of behaviour, activities, mood and engagement with staff. Physical health issues were followed up as required, patients were supported with daily personal hygiene routines and the use of safe clothing was initiated and reviewed by the MDT.

Safeguarding

- Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training with an overall compliance rate of 92%. Staff were able to give clear examples of types of abuse.
- Staff worked with other agencies to report safeguarding alerts and took part in safeguarding meetings with the local authority who reported an improvement in the quality of safeguarding referrals. The hospital had also recently implemented a working protocol between the local authority and the police to clarify which party would investigate or take action for particular safeguarding incidents.

Staff access to essential information

- Staff had easy access to secure clinical information, although reported that electronic systems were often very slow, making it difficult to input records in a timely manner. Staff were also unsure of where specific patient records were stored, such as PBS plans and physical health care plans.

Medicines management

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, staff did not always log the expiry date for opened medication, this had been regularly identified on the medication audit. We found there was a lack of timely response to audits conducted by the local pharmacy. We also found a delay of five months between an incident investigation of a controlled drug going missing, and the subsequent review of this investigation.

Reporting incidents and learning from when things go wrong

- The service had high numbers of incidents. In January 2021, there were 412 incidents at the hospital, 317 in February and 361 in March. This was an increase compared to our last inspection in December 2020.

- Staff knew what incidents to report and how to report them on their internal incident reporting system. Despite staff reporting incidents internally in line with the provider's policy, not all incidents specific to each patient were recorded in the patient's clinical notes.
- Staff did not follow or consider duty of candour following incidents. When we asked the hospital about this, we were told there were no incidents that had occurred that would warrant duty of candour, despite the providers policy outlining that duty of candour should be followed for all serious incidents. No rationale was offered as to why duty of candour had not been applied for all serious incidents.
- Staff received feedback from some reviews of incidents at the service in the form of lessons learned bulletins which were produced monthly for each ward. Staff were provided with information on themes from incidents and specific actions in order to reduce the likelihood of the incident occurring again. Managers also shared learning in morning meetings, communication books and emails to staff. However, we were not assured learning was shared in a timely way following incidents. For example, we fed back a patient safety incident to managers in our December 2020 inspection regarding staff trapping a patient's arm in a seclusion door due to risk of assault. The provider had only highlighted this as learning in their February 2021 lesson learned bulletin. This risked the incident occurring again within this two-month gap, as not all staff were aware of the risk and learning.
- Managers held lessons learned meetings with staff, although not all agenda points were covered during the meetings. Staff did not discuss reviews or learning of specific incidents even though we found there to be several management reviews which had past the set date for review. The meeting often focused on how to record incidents rather than focusing on patient safety improvements. Actions from previous meetings were not reviewed or completed.
- Managers had analysed learning from patient self-harm incidents, however staff did not record any learning for 39% of self-harm incidents in February 2021 and had not ensured all learning was specific to the incident. In one example, a patient had occluded their airway whilst on the highest level of patient observations, with staff constantly observing the patient at arm's reach, yet no learning had been identified. However, a review of CCTV restraint incidents had been completed which highlighted areas of good practice and improvements which we saw had been shared with staff via a bulletin. We also saw an improvement in staff completing post injury checks for patients following restraint or safety incidents.
- Despite an improvement in the sharing of learning from incidents since our last inspection, we found that not all serious incidents were investigated thoroughly by managers. We found that out of 20 serious incidents since January 2021, only four reviews had been fully completed and it was unclear where serious incidents were monitored or discussed as these did not feature in the providers clinical governance meetings. This was not in line with the providers policy on incident reporting and investigation. One of the reviews that had not been completed was in relation to a patient voicing that they were unhappy with how they were restrained. Specific managers had not been allocated to complete reviews for serious incidents, it simply stated 'Ward MDT' to complete. Furthermore, for initial reviews that had been completed, learning points were contradictory. For example, one learning suggestion was to ensure the whole multidisciplinary team informed a client of a change to where he would be staying at the hospital, yet the next learning point advised that there were too many staff present when the patient was informed. Not all learning points from these reviews had been transferred to the corresponding action plan.
- Managers had not ensured that all recommendations from reviews were completed. For example, we found that actions to amend a patient risk assessment following an aggressive incident was not completed and other actions following incident reviews were left as 'ongoing' therefore it was not clear if they were completed. The providers incident management and reporting policy stated that managers should sample incident reports and check that actions have been completed, but we did not see any evidence of such checks. However, we found one recommendation from an incident review had been completed following a patient using a particular item to occlude her airway, this item was no longer easily accessible on the ward.
- Despite staff discussing recent incidents within ward morning meetings, it was not clear how serious incidents were escalated at the hospital. Managers had also not identified that learning from the serious incidents was contradictory, or that there were inconsistent dates on review documentation, actions plans from the reviews had not been fully completed and duty of candour had not been followed where required.

Inadequate

Wards for people with learning disabilities or autism

- We found that not all lower graded incidents had a management review within two to seven days of reporting in line with the providers policy. When managers did review incidents, this was often very brief and included no evidence of how they assessed if the incident was managed in line with the patients care plan. Incident reviews for lower graded incidents were often repetitive between different incidents such as 'patient was managed according to their care plan'.
- Staff told us that they would not always have time to hold a debrief following patient safely incidents, however staff informed us that they recently started to hold safety huddles on the wards to support one another.

Are Wards for people with learning disabilities or autism effective?

Inadequate

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

Assessment of needs and planning of care

- Staff assessed patient's physical health needs soon after admission and reviewed physical health needs on a regular basis in most cases. Out of 17 patient records which we reviewed, we found two patients who did not have a physical health assessment on admission, however physical health had been reviewed on a monthly basis thereafter.
- Patients had COVID-19 passports which included their vaccination record. On Redgrave ward, we found patients hospital passports were out of date and had not been updated since 2020. However, when we visited Walsham ward the following day, patient's hospital passports had the previous days date on them, yet the patient information remained out of date and incorrect, such as the dose of a patient's medication.
- Staff developed care plans for each patient, however these did not always include all of their mental and physical health needs. The quality of patient care plans also differed between wards. We found good quality care plans on Bure ward, however on other wards care plans were complicated, overly detailed, appeared to have been copied and pasted across patients and did not describe all of the patients physical health conditions or detail a plan of how to safely manage all patient needs.
- Staff were not always managing patients in line with their care plans. One patient suffered from epileptic seizures, however staff had not always managed this in line with the patients care plan as physical observations were not always taken following the patient suffering a seizure. Section 17 leave had also not been completed in line with their care plan as they required an accompanying nurse which had not occurred.
- Care plans were regularly reviewed within multidisciplinary team meetings and often reflected patients views although would not always use language which was easy to understand. Easy read care plans were not always completed for patients who needed them, although we did find evidence that specific easy read plans were created for specific health conditions such as diabetes.
- Positive behaviour support (PBS) plans were present in all bar one of 17 records we looked at however PBS plans were not regularly reviewed. A behaviour support plan contains a range of strategies to focus on positive behaviour support approaches when managing challenging behaviour to ensure the person has access to support that is tailored to them. PBS plans were not easy for staff to locate, were overly complicated and lacked clear information for staff to provide appropriate care and support to patients. The provider had told us prior to the inspection that PBS 'grab sheets' were being used on Redgrave ward, for staff to easily identify patient needs and support strategies. However, we found two PBS 'grab sheets' in place at the inspection, but staff told us that they were not sure how they should be using these. We found one PBS plan that had not been updated since 29 October 2020. For another patient who was in long term segregation, their PBS plan did not reflect they were in long-term segregation. It did not reflect the triggers associated with long-term segregation and how these were to be reduced.

Best practice in treatment and care

Inadequate

Wards for people with learning disabilities or autism

- Patients had limited access to care and treatment suitable for their needs. Psychological, therapeutic sessions and patient activities were sparse, and we found that some patients were only offered one activity per week, and in one case we could not see any activities offered to a patient. We saw one patient who was waiting four months for a follow up appointment following an initial psychological assessment. Despite patient PBS plans referring to individual patient activity timetables, when we asked to see these, staff told us that they did not have individual activity timetables. Ward based activity timetables were available, however ward-based activities often failed to link directly to the goals and care needs of individual patient care plans or PBS plans. Staff and patients told us that activities were affected by staffing levels as staff would need to facilitate patient observations, leaving little time to facilitate ward-based activities. Activity staff would often be called upon to support patient observations and if one patient was taken off the ward to access leave or ground walks, there would be no other staff to facilitate activities on the ward.
- We did see some good practice in specific therapy sessions delivered such as trauma informed treatment and support for emotional regulation. However, speech and language therapists were not working towards a defined practice model and there was limited in-house support available. We saw one full speech and language assessment which provided recommendations for how staff should best engage the patient, how to support the patient to manage emotions and how to support social communication needs. Despite this positive piece of work, this had not been replicated for all patients with communication needs.
- Staff did not identify and record all patients' physical health needs in their care plans. Staff did not escalate signs of clinical deterioration in patient health, such as a high pulse, or compete further physical observations in response. Staff were not completing physical health observations as prescribed in patient care plans and some care plans did not detail the frequency of physical health monitoring. We also found an array of unmet physical healthcare needs. This included a lack of planned care for asthma, incontinence and lack of consideration for the side effects of medications. We raised this with the provider at the time of the inspection, who re-visited all patients care plans in relation to these concerns.
- Staff did not consider all patients' dietary needs and there was a lack of specialist care for nutrition and hydration. Food and fluid intake, weight and BMI (body mass index) measurements were often not recorded in patients' records. For patients whose care plan stated they were under the care of a dietician, there was limited input from any dietician since August 2020. We saw that two patients had an obesity plan, however staff were not fully supporting the patient with this, other than providing generic healthy eating advice. There was no input from a dietician for one patient who was diabetic.
- Staff roles and responsibilities were unclear for supporting patient's physical health needs or monitoring of physical health and information on such needs was not shared effectively between physical health staff and ward staff. It was not clear who had oversight of physical health, staff did not complete physical health audits and there was no clear plan of action to resolve these issues.
- Staff ran a 'Live Well' forum, however this was not well-attended, not all agenda points were discussed as meetings were postponed and staff attitudes were unresponsive in encouraging patients to make better health decisions. Actions points from previous meetings were not completed, such as an action to recruit physical health champions. Staff agreed that further work was needed to support patients to live healthier lives.

Skilled staff to deliver care

- The hospital did not have full access to a range of specialists to meet patients' needs. Access to dieticians was limited and resources were stretched within the therapy team. We saw a lack of speech and language assessments, staff told us they felt under-resourced and that they did not always have time to update care plans in relation to such needs. Managers informed us of gaps in therapy posts over a 4-year period and there had been no occupational therapist on Redgrave ward for many months. Staff also reported difficulty in ensuring doctors attended care planning meetings.

- Managers had not ensured that agency staff had the right skills or experience to meet the needs of patients in their care. Agency staff lacked mandatory training including safeguarding and breakaway techniques, not all agency staff were provided with an induction and most agency staff had limited or no experience of working with patients with learning disabilities or within a secure environment.
- Managers did not support staff through regular, constructive clinical supervision of their work. Supervision completion figures ranged from four per cent in January 2021to 19% in March despite the provider's policy stating this should occur monthly. This is a risk to patients and staff as supervision is a vital tool to support staff in developing their practice, performance and providing support and accountability. There was a lack of oversight of the supervision process from senior management. Furthermore, agency staff did not receive any form of supervision which was a significant risk given the high percentage of agency staff working at the hospital. Therapy staff held reflective practices sessions for staff in April 2021 and informed us that they were re-launching these sessions to support staff.
- Permanent staff employed by the organisation had the appropriate employment checks in place and were experienced in their roles although the hospital lacked specific learning disability nurses.
- Managers were completing annual appraisals for staff at the time of the inspection, with 66% of staff provided with an appraisal in 2021 and the remaining 34% due to be completed by the end of May 2021.
- Staff attended brief morning meetings and handovers to share information from the previous 24 hours. However, managers did not hold regular full staff team meetings and staff reported missing key information.
- Therapeutic staff were able to request bespoke training such as sensory processing training. However, infection prevention and control (IPC) staff were not provided with specialist IPC training. This was highlighted at our previous inspection. Managers did not routinely identify specific training needs for nurses and healthcare assistants. Staff reported opportunities for development and career progression through apprenticeships and support with academic qualifications. However, the provider had not established nursing associate roles at the hospital.

Multi-disciplinary and interagency team work

- Staff held regular multidisciplinary (MDT) meetings however further work was needed to ensure all risk factors and care needs were discussed and taken forward. For example, staff did not review a patient's epilepsy care plan during their MDT meeting despite this being a current prominent risk. Patient observation levels were not always reviewed during MDT meetings. Staff did not check patients were involved in or understood their observation levels. MDT reviews of patients in long term segregation (LTS) did not always document what stage their LTS plan was at. Our observations of MDT meetings highlighted that staff were not always setting actions to address changes in patient presentation and staff were not entirely sure on the processes of MDT meetings, such as what information they should be reviewing. A patient was not present for their MDT which we observed. Staff told us that patients were invited, although staffing levels sometimes impacted whether a patient could attend, and other patients did not always wish to attend. Staff told us that patients would receive feedback from the MDT meeting if they did not attend.
- Staff held handover meetings in which they discussed patients, including information such as safeguarding incidents, staffing levels, and patient observation levels. However, we were not assured that all information needed to provide appropriate care and treatment to patients was being shared across the hospital. Staff told us of inconsistent attendance at handover meetings and patients also told us that night staff were not fully aware of their risks or actions required to manage their risks.

Adherence to the Mental Health Act and Mental Health Act Code of Practice

- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice, 92% of staff were trained in the Mental Health Act.
- Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support.

Inadequate

Wards for people with learning disabilities or autism

- The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.
- Staff informed us that automatic referrals were made to advocacy services for patients when they arrived at the hospital. We observed details of independent mental health advocates advertised on ward notice boards and we saw that the hospital safeguarding lead provided updates to the independent advocates of relevant safeguarding incidents via email. However, advocates informed us that they had not been able to access wards since the COVID-19 pandemic began and they found that one patient had not had contact with an independent advocate since being admitted to the hospital in 2018. Furthermore, we found one seclusion record in which the patient had not been asked if they wanted to see an independent mental health advocate.
- Staff explained to most patient's their rights under the Mental Health Act and repeated and recorded it clearly in the patient's notes each time. However, one patient was not reminded of the information until two months after their admission. Usually patients received reminders about their rights at the time of the renewal of their detention, however, one patient was not reminded of the information until one month after their detention was renewed.
- Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Staff ensured section 17 leave papers documented clear parameters of patient leave such as the frequency, duration and location. The MHA administrator audited section 17 leave for restricted patients each month to check that their conditions of leave had not been breached.
- Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Where possible, the MHA administrator requested copies of detention papers before the patient was admitted to carry out an initial check and on admission the MHA administrator received and scrutinised the documents. All files contained the appropriate detention forms, transfer documents and renewal documents where relevant and the MHA administrator had a system in place for reminding clinicians of detention expiry dates.
- Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

- Staff received and kept up to date with training in the Mental Capacity Act, 88% of staff had completed this training.
- Staff did not always assess and record patient's capacity. We checked 14 patient records for patient capacity assessments, and nine records did not have any evidence of a capacity assessment. For patients in seclusion we also found that two patients did not have an updated capacity and consent assessment form when a new drug was added. However, we found one example of staff supporting patients to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff had written to the GP to suggest a best interest meeting for a patient in relation to diabetes.
- The service was not monitoring how well it followed to the Mental Capacity Act and it was not clear how the service was monitoring any changes that may be needed to improve.

Are Wards for people with learning disabilities or autism caring?

Inadequate

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

Kindness, privacy, dignity, respect, compassion and support

- Our findings from the other key questions demonstrated that the service was not always caring for patients with respect or providing treatment that met the patient's basic needs. For example, our findings demonstrated staff

sleeping whilst meant to be completing patient observations, physical health concerns were not always escalated, acted upon or documented, patients capacity was not frequently checked, and patients prescribed observation levels were not always adhered to by staff. Additionally, patient self-harm was not always responded to resulting in injury to a patient. Patients experienced a lack of basic activity and delays in accessing specialist treatment, and not all care needs were reviewed or addressed. Negative patient and carer feedback relating to the care and quality of the service was not always responded to and governance processes were not supporting patients to receive care of a good quality to meet their individual needs.

- Patients and staff told us that there were often too few female staff on duty to care for female patients, particularly at night time. A female patient reported that only male staff were available on two occasions which they said made them feel uncomfortable, particularly when male staff provided personal care whilst on their constant observations. Staff had not always ensured patients preferences had been recorded in relation to the gender of observing staff when a patient was in seclusion.
- Most staff used appropriate communication methods to support patients, however patients did inform us of three staff who would speak in a different language in front of them which made them feel uncomfortable and frustrated.
- We observed positive interactions between staff and patients in which patients were supported with daily living tasks. Patients told us that staff treated them well and behaved kindly.
- Staff supported patient's privacy and dignity in most incidents which involved physical restraint. We saw staff use towels, blankets and privacy screens to preserve patient dignity. However, staff did not always direct other patients away from the incident when they had the opportunity to do so, resulting in other patients watching a patient being restrained.
- Staff followed policy to keep patient information confidential.

Involvement in care

- Staff involved patients in care planning, risk assessment and decisions about the service. Staff used communication aids to support some patients with communication difficulties however, some patient care plans were not always written in a simple language.
- Most staff we spoke with understood the individual needs of each patient. However, patient care plans did not always demonstrate the specific individual needs of each patient. For example, communication and religious needs were not clearly documented in patient care plans. We were therefore not assured that all staff, including the high percentage of agency staff that worked at the hospital, were aware of all patients' individual needs. Patients were offered a copy of their care plan, although some patients who we spoke with reported they did not have up to date copies of their care plans, with one patient's copy dated from 2019.
- Patients could give feedback on the service and treatment they received, and staff supported them to do this. Staff regularly held community meetings on each ward for patients to feedback their views on the service. However, it was not clear from the community meeting minutes how actions were being taken forward and we found similar concerns were raised regularly in concurrent meetings, such as patients feeling unsafe and bullied by other patients. Staff informed us actions were shared via email and in comment books, however staff also informed us they were often too busy to check their emails.
- Staff involved families and carers within patient care and provided opportunities for carers to give feedback on the service. Carers who we spoke to had mixed views on staff, with one carer noting how staff were polite and were happy with their involvement in patient care, however another carer felt that staff brushed complaints under the carpet. The hospital completed a carer satisfaction survey which demonstrated a negative trend as carers were more likely to disagree with positive statements about the hospital. It was not clear how managers were taking these concerns forward.

Are Wards for people with learning disabilities or autism responsive?

Inadequate

Wards for people with learning disabilities or autism

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement because:

Access and discharge

- Due to concerns we found at our previous inspection in December 2020 the provider ceased to admit new patients to the service. Prior to this, the hospital's admission criteria had not been clear which meant that it had admitted patients with acute complex and challenging conditions whose needs could not be met by the service. Since, the clinical team had completed a review of all patient's suitability against the hospitals admission criteria and were in the process of finding a number of patients a more suitable service provision. Staff were assessing and planning patients' discharges and were engaging with care managers and commissioners. The provider identified that many patients needs were complex, and that an alternative provision was required to ensure their needs were being met. Despite the providers strong efforts to re-locate patients who required an alternative provision, many patients had not been able to move on from St Johns House. In total, there had been 10 discharges or transfers since our last inspection, however patients who required the more complex care packages remained at St Johns House.
- Patients were only moved between wards with a clear clinical reason or if it was in the best interest of the patient.
- Despite patient discharge and transfer plans, patient documentation including clinical notes and care plans were not kept up to date with this information and we were therefore not assured that these plans were fully communicated to patients.
- The service had a high number of out of area placements. Thirty-three of 35 patients were from other areas of the United Kingdom and the Republic of Ireland. The average length of stay for patients at the hospital was 2.7 years, however patient stays ranged from 5 months to 9 years 7 months.

Facilities that promote comfort, dignity and privacy

- Each patient had their own bedroom, which they could personalise, and patients had a secure place to store personal possessions. Patients were not able to freely access hot drinks on all wards as access to the servery area was deemed a risk to patients. Patients were provided with drinks by staff, however we did not see staff offer patients a choice of drink, as we observed that patients were all provided with the same drink during the day.
- Staff used a full range of rooms and equipment to support treatment and care. The service had designated quiet areas, a TV room, multi faith room, an easily accessible outside space, a private room to make phones calls and a room where patients could meet with visitors in private. Staff individually risk assessed most rooms before patient use. Despite the ward quiet areas, we found Redgrave and Waveney wards to be noisy, even when in the quiet rooms. This did not meet the needs of patients with autism on the wards. Therapy staff also reported that due to the noisy and chaotic environment, it made therapeutic interventions difficult to complete on wards and would be over stimulating for patients with autism.
- Staff offered patients a menu of food although patients frequently requested changes to food at the hospital. Staff made changes to the menu's following patient requests.

Patients engagement with the wider community

Inadequate

Wards for people with learning disabilities or autism

- Staff helped patients to stay in contact with families and carers. Staff facilitated visits from patient's children and access for patients to attend family events. Staff reported the negative impact of the COVID-19 pandemic on patient access to the wider community. However, staff were planning to review hospital guidelines on community engagement and visits due to the current pandemic restrictions lifting.

Meeting the needs of all people who use the service

- The hospital was not able to accommodate patients with a physical disability. This was set out in the hospitals' admission criteria.
- Staff made sure patients could access information on treatment, local services, their rights and how to complain. Patients were able to request information leaflets available in other languages.
- Staff had ensured that for one patient who identified as a Muslim, they were able to eat halal food and was supported to use the multi-faith room. However, the patient did not have a care plan which identified his religious needs, so we were not assured that all of the patient's needs were being met or that all staff were aware of his needs. We found that the multi-faith room was also regularly used to de-escalate other patients on the ward therefore we were not assured that this patient was able to routinely access the multi-faith room for their religious needs.

Listening to and learning from concerns and complaints

- Most patients knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.
- Staff understood the policy on complaints and knew how to handle them. Ninety-six per cent of staff had completed and were up to date with their complaint training.
- There had been five formal complaints since January 2021. Managers investigated complaints however despite an agreed extension for one complaint, this timescale had not been met. It was also unclear from two complaint responses whether staff had fully ensured the patient felt safe or was happy with the action taken. For example, it was raised that a patient was staying in their room due to fear of other patients on the ward. Staff responded to the complaint by reporting that the patient chooses to self-isolate depending on their mental state and did not fully explore that the patient may be confining themselves to their room because they were in fear of other patients.
- Managers did not always share feedback from complaints with staff to use as learning to improve the service.

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

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate because:

Leadership

- Leadership at the hospital had been inconsistent leading to a lack of staff direction. Since July 2020, there had not been a registered manager at the service. A total of four temporary managers had covered this role since that time. Since January 2021, there had been a consistent temporary operational manager who has developed a good understanding of the challenges of the service. Since, the service was also receiving additional support from managers from other services and executive level staff from the wider organisation. Temporary cover of the registered manager role has resulted in a lack of clear leadership and understanding of the service as each manager has taken time to

develop their knowledge of the service. In addition, due to the hospitals vacant position of medical director, we were not assured that there was suitable oversight of aspects of mental and physical healthcare. We found a lack of oversight for physical health monitoring and it was not clear how medical governance processes were being monitored.

- Staff reported that not all senior managers were visible in the service, although staff and patients felt comfortable in approaching some managers. Staff were aware of the provider's whistleblowing policy and felt confident to use it. Staff spoke highly of the overall operational manager who had been overseeing St Johns House since January 2021, as they felt she was committed to improving the hospital and was visible on wards.

Vision and Strategy

- Not all staff knew and understood the provider's vision and values, however staff felt involved in developing the service. Staff felt that communication of key decisions between managers and staff could be improved.

Culture

- Staff felt respected and valued, however many staff felt stressed and reported concerns of under staffing which impacted staff morale. Staff felt supported with COVID-19 related matters such as access to testing, vaccination and personal protective equipment. Staff reported positive team working with one another and we observed effective team coordination in relation to a restraint incident on a ward. Managers had recently introduced a number of wellbeing and recognition initiatives for staff in the form of therapeutic activities and items.
- However, staff did not feel that managers addressed racist abuse towards staff from patients. We saw therapeutic staff supported cultural sessions on wards, however there was no equality and diversity lead at the service and no forum for staff to raise concerns of this nature.
- Staff sickness between January and March 2021 was nine per cent. One staff member described a lack of support to staff members who were suspended from working at the hospital or on sick leave for long periods of time due to injury. They reported that they did not receive welfare calls whilst off work.
- Therapeutic staff felt that senior management did not always support the need for increased resources at the hospital to support patients with specific learning disability needs or speech and language needs.
- Managers had facilitated staff listening groups and a staff survey in which staff fed back concerns to management and generated a 'you said we did' action plan in March 2021. Despite managers efforts to address staff concerns regarding team morale and appreciation, some of the issues that staff were raising related to the stress of low staffing at the hospital which had not yet been fully addressed.
- Managers acted promptly to deal with poor performance from staff at the hospital by suspending staff who we identified to be sleeping whilst meant to conducting patient observations. Managers were continuing to investigate staff conduct concerns which we found in our December 2020 inspection.
- Staff reported opportunities for development and career progression through apprenticeships and support with academic qualifications.

Governance

- Our findings from the other key questions demonstrated that governance processes were not yet operating effectively. Managers had not identified incidents where night staff were sleeping on duty, despite previous concerns and internal assurance processes. We found staff sleeping on patient observations in our last inspection. Staffing levels also remained a problem alongside patient care and support needs not always being met.
- The provider had attempted to improve their governance systems however these had not led to sustainable improvement as demonstrated by the findings of this inspection. Managers followed a framework for hospital

meetings including clinical governance and lessons learned meetings. However, managers had not ensured that all clinical governance meetings were well attended, and we found a lack of action points in relation to particular concerns and it was not clear from meeting minutes if previous actions had been completed. Managers had not addressed the lack of staff supervision in their clinical governance meetings despite this ranging from between four and 19 per cent between January and March 2021. Managers did not review all quality issues which had been highlighted in their quality improvement plan and we were not assured who had complete oversight of this plan and where it was monitored. However, during the most recent clinical governance meeting, we found comprehensive reports submitted from key departments and managers reviewed trends in incidents and compliance rates for audits and training. Staff also received a briefing following the last clinical governance meeting which provided an overview of issues that had been raised and areas where improvements were required.

- Managers had not yet fully embedded effective systems and processes, such as regular audits of the service, to assess, monitor and improve the quality and safety of the hospital. The hospital had an annual audit programme which included audits of ligatures, the Mental Health Act, safeguarding, infection prevention control and supervision. Despite staff completing some of these audits, other audits such as the supervision audit had not been completed to timescale with no clear rationale. Furthermore, the provider was not completing audits of physical health. An external pharmacist completed a pharmacy audit, however due to the absence of a medical director and a medical review committee, there had been no clear oversight of the issues raised within these audits. Audits which had been completed did not always have timebound action plans to take forward issues which had been identified. Staff recognised that audits were not completed regularly every month, but rather once a year, and told us of plans to complete interim audits going forwards.
- Following our December 2020 inspection, the provider had created a site improvement plan in line with the concerns found at the inspection. However, despite a comprehensive overview of the initial issues found, the provider had not demonstrated a complete understanding of their own progression against the required areas for improvement. The provider had rated each area either amber or green, despite the concerns we found in relation to lack of adherence to the providers patient observation policy, low staffing levels at the hospital and lack of oversight of incident reviews, medical governance and staff supervision. We were therefore concerned that the provider did not have an accurate overview of risk or quality of the service.
- However, managers had introduced quality walk around checks covering patient experience, patient records, the environment and the physical health of patients. Specific issues were identified within these checks, however actions needed to resolve the issues were not always clear and there was no named owner or evidence these had been completed. Managers informed us of an expectation that actions identified in these reviews should be promptly completed, however it was not clear how this was monitored.

Management of risk and performance

- Managers created and updated a risk register which included the hospitals main risk areas, and staff concerns matched those on the risk register. However, managers did not have sufficient oversight of key issues at the hospital that were putting patients at risk. For example, we found that agency staff would often not turn up for work when scheduled, as the hospital relied heavily on agency staff, low levels of staffing would affect the care that patients received. Managers had a recruitment strategy in place however this had not yet had a completely positive impact on staffing levels on the wards. During the first weekend of May, levels of staffing were so low that regional support was required and despite this there were not enough staff to cover patient observations. Other risks which we identified within our findings from other key questions included a lack of staff breaks from patient observations, lack of adherence to mandatory training for agency staff, duty of candour not being followed appropriately, no oversight of staff supervision and a lack of improvement in patient records such as risk assessments and care planning. The lack of improvement within these areas, despite the providers efforts, demonstrates the service has further work to do in order to ensure patient safety and a better quality of service for patients.

Inadequate

Wards for people with learning disabilities or autism

- Managers did not investigate all serious incidents and those that were investigated, did not identify appropriate learning or follow duty of candour processes. Where learning had been identified, this had not been shared with staff in a timely way. Recommendations from reviews were not always implemented and there was no oversight or monitoring to check they had been. We found that not all lower graded incidents had a management review within two to seven days of reporting in line with the providers policy. When managers did review lower graded incidents, this was often very brief and included no evidence of how they assessed if the incident was managed in line with the patients care plan.
- The service had an emergency continuity plan in place covering what to do in the event of major emergencies such as fire, loss of utilities or a pandemic. This had been updated throughout the COVID-19 pandemic.
- Managers collected data about the hospital for bespoke reviews such as self-harm incidents and patient debrief compliance. However, there were a lack of actions from the review of self-harm incidents and we were not assured that all findings had been shared with the wider staff group or that checks of learning from the reviews had been completed. Further work was required to ensure incident analysis was being used to drive quality improvement at the hospital.
- Managers collected performance data over time in line with contract requirements. We were informed that the assurance and contracts coordinator was working on a key performance indicator dashboard to highlight a range of themes at the hospital including serious incidents, restrictive practice, seclusion and long-term segregation, complaints and patient records. This was not in place during this inspection, but we were told would be implemented in due course.

Engagement

- Managers had written to staff, patients and families in relation to our last inspection in December 2020 to inform them of the issues found and what action was being taken in response. Patients were also provided with regional 'News and Views' booklets to engage them in local activities and achievements.
- Patients had opportunities to provide feedback about the quality of care and treatment at the hospital. Staff facilitated ward community meetings in which they voiced what they did and didn't like, and suggested areas for improvement. However, it was not clear how patient suggestions were taken forward from this meeting and we saw the same patient suggestions had been raised in subsequent meetings, suggesting not all points had initially been implemented.
- Patients also had the opportunity to participate in a survey of the hospital. However, in the 2021 patient survey, only 43% of patients reported feeling safe and 37% of patients said there were not enough things to do. Patients told us that they did not receive feedback from the survey, and it was not clear how this feedback had been taken forward. The provider told us a patient was present in their clinical governance meeting however the meeting minutes did not detail the patient's voice or record outcomes for patients consistently. However, staff told us of patient involvement within the introduction of the 'safe wards' initiative at the hospital which we were told was being rolled out soon to reduce conflict and increase positive interactions.
- Patient relatives were able to complete a satisfaction survey in December 2020 however the provider had not yet analysed the results despite negative comments and a negative trend compared to the last survey.
- Senior leaders engaged with other stakeholders, including commissioners through visits and telephone calls. Managers had reached out to local partners such as the local safeguarding authority and police to further develop working relationships.

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 Diagnostic and screening procedures	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

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 17 HSCA (RA) Regulations 2014 Good governance

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 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 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers

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 20 HSCA (RA) Regulations 2014 Duty of candour

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 9 HSCA (RA) Regulations 2014 Person-centred care

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 11 HSCA (RA) Regulations 2014 Need for consent

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

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Diagnostic and screening procedures

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment