Partnerships in Care Limited

St Johns House

Inspection report

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

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

This service was placed in special measures in December 2020 and remained in special measures following a further inspection in April 2021.

As this was a focused inspection, we did not re-rate the location. Therefore, the previous rating of inadequate remains unchanged. Insufficient improvements had been made and the service remains in special measures.

Following this inspection, based on the impact and seriousness of our findings, we issued the provider with an urgent Notice of Decision imposing further conditions on the providers registration. The conditions we placed on the hospital's registration in December 2020 also remain in place.

This inspection was an unannounced, focused inspection to review key areas of risk relating to patient safety, incident management and safe staffing. We looked at specific key lines of enquiry during this inspection therefore we reported in the following domain:

- Safe

We found the following areas of concern:

- The service did not have enough nursing and support staff to keep patients safe. Staffing levels were below the number needed to maintain patient observations.
- The provider had not ensured that patient observations were completed in line with patient care plans or the providers patient observation policy. We reviewed CCTV footage and found staff were asleep whilst completing patient observations. We found this concern during our previous two inspections of this service.
- We found staff were completing patient observations for up to six hours continuously, despite the provider's policy stating this should not be for longer than two hours. Managers told us of an incident in which intermittent patient observations were not completed for up to six hours for at least three patients with no explanation as to why this occurred. Staff were not always seeking permission from an on-call doctor to reduce a patient's observation levels which was against the provider's policy.
- Male staff were often placed on intimate female patient observations due to the shortage of female staff. On one occasion, this resulted in a delayed response from observing male staff to respond to a patient suspected of self-harming.
- The service had high rates of agency staff and during the night we found that some wards were operating solely on agency staff.
- Agency staff did not all have adequate training or experience. This included mandatory training such as safeguarding for adults and children, breakaway techniques, first aid, basic life support and the Mental Health Act.
- Patients in long term segregation did not have access to constant fluids in the segregation area.
- The service did not always manage patient safety incidents well or respond to changes in patient risk. Staff did not always respond appropriately to patients who were self-harming, on one occasion this resulted in injury to a patient. During a separate incident, staff did not immediately transfer the patient to the Accident and Emergency centre when required.
- Managers had not acted to prevent patient safety incidents from reoccurring. We raised concerns relating to various patient safety incidents during this inspection which we also found at our previous inspections of the service. This demonstrated a lack of improvement and not learning from when things went wrong.

Summary of findings

- Staff did not follow the provider's policy when using restrictive interventions with patients. Staff using soft handcuffs on patients did not seek appropriate approval, were not appropriately trained and had not ensured a care plan was in place for the safe use of handcuffs.
- Staff did not report incidents clearly in the patient's clinical notes and failed to accurately report rationales for key decisions to protect patients from harm.
- Managers did not fully investigate incidents and learning from incidents was not always completed or shared with staff. When it was, learning points lacked context or were repetitive, making this ineffective at implementing changes.
- The hospital was not reporting all abuse or safeguarding allegations to the local safeguarding authority.
- Patients continued to be exposed to harm in key risk areas such as staffing levels and staff not completing patient observations appropriately. Managers told us that since our last inspection in April 2021, night-time checks were in place to ensure staff were not asleep and daily CCTV reviews were taking place to check that staff were awake. However, managers told us they had not identified any staff asleep, despite the findings of this inspection. This demonstrates that the provider's governance processes were not operating effectively, and that performance and risk had not been addressed or improved.

However:

- Permanent staff employed by the provider had completed and kept up to date with their mandatory training.
- Managers provided an explanation to patients when things went wrong in three out of 17 incidents which we reviewed. This was an improvement since our last inspection.

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	Inspected but not rated	

Summary of findings

Contents

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 29 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 11 patients on this ward.
- Walsham ward which was a 16-bed medium secure male ward. There were 10 patients on this ward.
- Bure ward which was a 11-bed low secure female ward. There were four patients on this ward.
- Waveney ward which was a six-bed low secure female ward. There were four 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 since this time.

Following a risk based focused inspection in December 2020, the hospital was placed in special measures and rated as inadequate overall and within the domains of Safe and Well-led. Following the December 2020 inspection, we imposed urgent conditions on the provider's registration at this location including preventing the provider from admitting further patients to the hospital.

During an inspection in April 2021 we rated the hospital again as inadequate overall and within the domains of Safe, Effective, Caring and Well-led. Responsive was rated as Requires Improvement. The hospital remained in special measures.

Following this inspection in July 2021, based on the impact and seriousness of our findings, we issued the provider with an urgent Notice of Decision imposing further conditions on the providers registration.

The purpose of this inspection was to review key areas of risk that we identified during previous inspections, relating to patient safety. We did not re-rate the location during this inspection. As we looked at specific key lines of enquiry during this inspection, we have reported in the following domain:

- Safe

Summary of this inspection

What people who use the service say

We spoke with two patients during this inspection. One patient raised concerns that there were not enough staff during the night. The other patient who we spoke with said they did not feel safe in their bedroom as they frequently experienced seizures and their alarm to call for staff assistance was located near their door rather than beside their bed. They were concerned that they could not call staff for help. We raised this with the service and the following day staff moved the patient's assistance alarm to beside the bed.

How we carried out this inspection

The purpose of this inspection was to review key areas of risk that we identified during previous inspections, relating to patient safety. We did not re-rate the service during this inspection.

During the inspection, the team:

- spoke with two patients who were using the service
- spoke with three managers of the service including ward managers and senior managers including the medical director
- spoke to six other staff including permanent and agency staff nurses, healthcare assistants and administration staff
- looked at five care and treatment records of patients
- looked at staff records and training
- reviewed staffing levels
- reviewed incident logs, forms and reviews
- reviewed CCTV footage of incidents
- looked at a range of policies, procedures, meeting minutes, hospital data and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. 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.

Action the service MUST take to improve:

Requirements made following this inspection:

- The provider must ensure patients in Long Term Segregation have constant access to fluids whilst in the segregation area (Reg 14(1,2 and 4))
- The provider must ensure patients are transferred to the Accident and Emergency centre, without delay, following incidents where this is required, as outlined in the provider's policy (Reg 12(2){i})
- The provider must ensure patients are offered appropriate support and protection following involvement within a safeguarding incident (Reg 13(1-4))

Summary of this inspection

- The provider must ensure they follow national guidance and the provider's policy when using mechanical restraint on patients, including seeking appropriate approval, ensuring patients have an individual care plan for the use of handcuffs, ensuring staff are adequately trained in the use of handcuffs and providing an appropriate debrief to patients on the use of handcuffs (Reg 12(a, b, c and e))
- The provider must ensure they report all allegations of abuse or reportable safeguarding incidents to the appropriate authorities (Reg 13(2-3))
- The provider must ensure that the reporting of incidents is clear, accurate and details the rationale for decisions made in relation to patient care and safety (Reg 17(2){b})

Requirements made following previous inspections and again identified during this inspection that the provider must meet:

- 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 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 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 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 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 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})

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	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Wards for people with learning disabilities or autism

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Wards for people with learning disabilities or autism safe?

Inspected but not rated

We did not re-rate this service. The rating of inadequate from the inspection in April 2021 remains unchanged. As this was a focused inspection, we did not review all key lines of enquiry under this domain.

Safe and clean care environments

- Ward areas were clean and well maintained. However, ward areas were uncomfortably hot due to the hot weather and staff told us there was a problem with the air conditioning. We observed a patient in long term segregation who did not have fluids available within the segregation area, despite the hot weather. Staff in the area confirmed this. We raised this with managers at the service who confirmed maintenance were fixing the air conditioning and would ensure the patient had constant access to fluids.
- One patient we spoke with reported feeling unsafe as her assistance alarm in her bedroom was positioned near the bedroom door rather than near the bed. As she experienced seizures, she was concerned that staff may not be able to respond to her as she could not reach the assistance alarm. We raised this with the service and the following day the patient's alarm had been moved to beside their bed.

Safe staffing

Nursing staff

- The service did not always have enough nursing and support staff to keep patient safe. On 18 July 2021, 26 June 2021 and 17 May 2021, due to agency staff cancellations and agency staff not arriving at the service for their pre-booked shift, patient observations were reduced due to low staffing levels. On 18 July 2021 a patient on Redgrave ward who should have three staff constantly observing them due to their level of risk and care needs, only had two staff observing them. Managers confirmed that this reduction in observation levels had not been clinically assessed by a doctor as required by the provider's supportive observations and engagement policy. Staff had not recorded any rationale as to why the patient's observations levels had been reduced in the patient's clinical notes. On 26 June 2021 two patients on Walsham ward who were on level 3 observations shared one nurse overnight instead of one nurse for each patient which poses a risk to both patients. If the staff member was attending to one patient, then the other patient would be left without a staff member observing them. By altering patient observation levels in line with staffing available, rather than as clinically assessed via patient risk and clinical need, this poses a risk of harm to patients.

- The service had high rates of agency staff. During the week of the 1 July 2021, 73% of staff on night shifts and 55% of staff on day shifts were agency staff. During the night we found that some wards were operating solely on agency staff. The service employed a workforce coordinator who used agency staff to fill staffing gaps and managers moved staff between wards to cover shortfalls on individual wards. However, staffing levels remained unpredictable each day, as rostered staffing figures differed to the actual staffing figures each day. During the week of 26 July 2021, rostered staffing levels versus actual staffing levels resulted in both more staff than anticipated and less staff than anticipated on different dates, including nine less staff than anticipated on 30 July 2021. Managers also informed us that there was no night manager present on the night of 23 July 2021, that management and therapy staff were deployed to work on the wards due to low staffing levels and that staff often had to 'sleep in' at the service to ensure adequate staffing levels. Staffing rotas also indicated that nurses were often replaced with healthcare assistants.
- Managers were able to evidence steps they had taken with staffing agencies in response to agency staff not turning up for their pre-booked shift, including introducing a three-strike rule that would result in the service not using the agency again if staff did not turn up for work when expected. However, despite these efforts and the services persistent attempts to recruit additional permanent staff, sourcing additional nursing agency staff, block booking agency staff for a six-month period, over-booking agency staff for each shift and holding daily staff resource meetings, staffing levels remained below the required levels in order to keep patients safe.
- Male staff were often placed on intimate female patient observations due to the shortage of female staff. During the inspection we reviewed an incident from the 27 June 2021 involving a female patient who was in their toilet area, suspected of self-harming. The patient's observing male staff did not enter the room as they waited for a female staff member to attend, due to the patient being in the toilet area. This poses a significant risk to the patient as there was a delayed response to a patient suspected of self-harming. Furthermore, only two female staff were on shift on the female ward, Redgrave, on the night of 25 July 2021 whilst two patients on the ward required constant observations. Managers confirmed that female patients did not always have a female member of staff on their constant observations due to the need for staff to take breaks from completing observations. We raised the incident from 27 June 2021 with the provider when we found this on 22 July 2021, however managers had not yet reviewed this incident when we asked again four days later. Since then, managers have attempted to source more female agency staff. Despite managers attempts, female staff levels remain low, including the night of the 30 July in which only two female staff were available on Redgrave ward. We raised this as an issue during our previous inspection of this service, therefore we remain concerned that female patients do not have access to female staff on their constant observations, risking the patient's safety and dignity.

Medical staff

- The service recently recruited a new Medical Director who described their intention to reduce the seclusion of patients and patient observations on the wards.
- There was an on-call system in place for medical cover however we were not assured that staff were using this appropriately as staff had not used this system to seek permission from an on-call doctor to reduce a patients observation levels on 26 July 2021.

Mandatory training

- Permanent staff employed by the provider had completed and kept up to date with their mandatory training. Overall, 90% of permanent staff were in date with their training.
- However, agency staff did not have adequate training or experience. We reviewed 31 agency staff profiles for staff who were working during the week of 19 July 2021 and found that for the 19 training courses that agency staff had completed, all had taken place over a two-day period. This included mandatory training such as safeguarding for adults and children, breakaway techniques, first aid, basic life support and the Mental Health Act. We were not assured

that two days was enough time to adequately cover 19 separate training courses. Furthermore, we found nine out of 31 agency staff were either out of date for their mandatory training or had not completed their mandatory training courses. Staff also told us of concerns about the experience and competency of agency staff, stating they did not always feel comfortable in working alongside them. As we found that high percentages of agency staff were used to cover shifts at the service, and that wards were sometimes solely staffed by agency staff, we were concerned that staff were not adequately skilled, trained or experienced to keep patients safe.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed risk assessments for each patient, and we found improvements in the accuracy of patient risk assessments compared to our previous inspection in April 2021. For example, patient observation levels were accurately recorded on patient risk assessments.
- The service completed a monthly audit of patient risk assessments and identified both good practice and areas for development. For example, the service found that risk assessments were not always updated following patient safety incidents however all risk assessments were now reviewed as part of a multi-disciplinary team meeting, except for one patient.
- Patient 'grab sheets' were available on each unit which concisely recorded patient behavioural triggers, risk factors and how staff should best support each patient. However, not all staff were aware of these and on Bure ward only one staff member had signed to say they had read these.

Management of patient risk

- Staff did not always act to prevent or reduce risks to patients. Staff were not completing patient observations safely, leaving patients at risk of harm. We reviewed a random selection of CCTV footage to observe how staff were managing patient observations at night, and to check that staff were awake when they were meant to be completing patient observations. We found that in three out of three checks staff were asleep whilst undertaking patient observations on the nights of 3 July, 4 July and 9 July 2021. Staff asleep whilst undertaking patient observations is a serious risk to patient safety as staff are not able to respond to the needs or risks of the patient or respond to an emergency, leaving the patient at risk of harm. During our previous two inspections of this service in December 2020 and April 2021, we found staff asleep whilst undertaking patient observations, demonstrating that managers had not addressed this safety risk.
- Managers told us that since our last inspection in April 2021, night-time checks were in place to ensure staff were awake and daily CCTV reviews were taking place to also check that staff were awake. However, since these checks were introduced in April 2021, managers told us they had not identified any staff asleep, despite the findings of this inspection. We requested evidence that CCTV checks had taken place prior to this inspection in July 2021. We were only provided with evidence of such checks from June 2021, not from April 2021 when we were told these were taking place. Staff reported that they did not always complete checks on staff during the night as this was often impacted by low numbers of staff on the ward. We were therefore not assured that managers had oversight or governance of key patient safety risks and managers had not taken adequate action to protect patients from harm.
- In the two-week period following this inspection, managers at the service informed us that within this period, they had found three further incidents of staff asleep whilst on patient observations. In one case, all three staff on a patient's 3:1 constant observations were found asleep. Managers told us they wrote to all staff at the service following these incidents to inform them of the risks of not adhering to patient observations and the consequences if staff were found to be asleep. Managers suspended all staff members who were involved from working at the service, however they were concerned of the impact this would have on already strained staffing levels.

- Staff were also completing patient observations for up to six hours continuously, despite national guidance and the provider's supportive observation and engagement policy stating this should not be for longer than two hours. Staff told us this was due to low staffing levels. We found that observation allocation sheets, used to inform staff of which patient they are observing, were not completed on all wards. Managers confirmed that these would not always be completed but that staff would be verbally told who they should be observing.
- Furthermore, managers told us that intermittent patient observations were not completed on Redgrave ward on the 18 July 2021 for up to six hours for at least three patients. Managers informed us they were investigating this, and that staff did not highlight this to an on-call manager. Managers did not believe this was because of low staffing levels, however, were unable to offer an explanation for why the observations were not completed. Patients are put at high risk of harm by staff not completing enhanced observations as prescribed and by staff observing patients for long periods of time as they are not able to respond to patient risk or an emergency.
- We reviewed 17 patient safety incidents and we found that staff did not always act to prevent or reduce risk of harm to patients. An incident which we reviewed on CCTV involving a patient who requested to use a side room due to noise levels on the ward, began to self-harm when they were left in the room. Halfway through the incident, a staff member looked into the room but did not respond to the patient. The patient continued to self-harm and staff later found the patient lying on the floor with an injury. The patient's positive behavioural support (PBS) plan provided specific guidance to staff on how intervene during this type of incident to prevent injury and actions to take following such an incident, however staff had not completed all of these actions. We requested the managers review into this incident and we found the review did not escalate any concerns with the incident, complete further investigation or share any learning to staff. We informed senior managers of this incident and highlighted the staff member who did not respond to the patient, to which managers suspended the staff member from working at the service and provided staff with learning from the incident via email.
- Staff had not acted to prevent risk of harm to a patient within a second incident we reviewed in which a patient swallowed a foreign object. Despite on-site medical advice and the patients care plan stating that an immediate transfer to the Accident and Emergency department was required if the patient experienced abdominal pain following swallowing a foreign object, staff did not immediately take the patient to hospital. We reviewed the patients clinical notes which recorded the patient complaining of abdominal pain and requesting to go to hospital however the nurse in charge of the ward insisted that day staff were exhausted and reasoned that as it was the end of the day, this would be handed over to night staff. This resulted in a delay in transferring the patient to the hospital which was also against the providers policy of management of ingestion – swallowing of foreign objects, which states that immediate transfer to the Accident and Emergency centre is necessary if stomach pain occurs. The management of this incident posed a serious risk to the patient's heath, as the ingested object may have been causing further harm to the patient.
- Staff had not acted in line with patient's care and support needs to prevent risk of assault. We reviewed two incidents in which one patient had been assaulted by other patients on two separate occasions. Managers informed us that one of these incidents involved three other patients who had targeted the patient over a period of approximately one hour, despite staff being present and attempting to diffuse the incident. We were notified of the second incident from the local safeguarding authority who told us that the same victim had been assaulted on a different day by another patient. The protection in place for the victim was for staff to encourage the patient to sleep in their bedroom and no further safeguards to protect or support either patient had been recorded. We raised our concern with managers at the service, who informed us that the assailant of the assault was offered medication to aid calming and was encouraged to spend time off the communal area to help with further de-escalation. Managers said they would investigate the incidents and would ensure multidisciplinary team members met with the victim to discuss their safety on the ward.

Use of restrictive interventions

- We found two incidents in which staff used soft handcuffs on patients when they presented as aggressive. Staff had not completed a care plan for the use of handcuffs for the patients and it was therefore unclear when staff should be using

handcuffs, if the patient or other multi-disciplinary team members should be consulted on the use of handcuffs or how to reduce any physical or emotional trauma resulting from the use of handcuffs. Staff had not always informed the senior nurse or sought medical approval from the duty doctor prior to using the handcuffs and not all staff applying the cuffs were trained in use of handcuffs. This is against the providers policy: prevention and management of disturbed violent behaviour. We raised this concern with managers who informed us they would complete a debrief with the patients following use of the handcuffs however when we reviewed evidence of the debriefs, staff had not spoken to the patients about the use of handcuffs, rather the overall incident of aggression and staff support.

- Levels of seclusion were high, with 17 instances of seclusion in May 2021, 20 in June and 28 in July, with the majority of seclusion episodes occurring on Redgrave ward. Seclusion episodes were less in May and June compared to levels at our previous inspection.
- Physical restraint incidents were high, with 71 reported uses of restraint in May 2021, 59 in June and 51 in July, with the highest episodes of restraint on Redgrave ward. This is a decrease in the use of physical restraint since our last inspection in April 2021. However, prone restraint had increased since our last inspection as there were three instances between May to July 2021, compared to zero between January and March 2021.
- Eighty-seven per cent of permanent staff were trained in the use of physical restraint. However, not all agency staff were trained in physical restraint or breakaway techniques. The service conducted a review of restraint incidents to identify if physical restraint was necessary, proportionate and that provider approved techniques were used. The review was conducted by an external specialist nurse who was a restraint lead in the organisation. The review shared areas for improvement for staff to improve their management of such situations, as well as highlighting good practice. For example, during supine restraint, the reviewer highlighted that holds were not being utilised incorrectly which could have led to safety issues. We saw these learning points shared to staff via bulletins.

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 89%.
- Staff were not reporting all appropriate incidents to the local safeguarding authority. We found an incident of neglect which had not reported to the local safeguarding authority until we raised this with them.
- Staff completed a safeguarding audit with patients in May 2021 in which staff identified a high non-response rates to questions such as 'Do you feel safe here?' and 'Has anyone explained what safeguarding is?'. Staff had not yet addressed the non-response rates by July 2021. As patients at the service experienced communication difficulties and learning disabilities, we were not assured that staff had ensured patients had understood the questions they were being asked within this audit and therefore staff had not ascertained if patients felt safe or understood what safeguarding was.

Track record on safety

- The service had high numbers of incidents. In May 2021, there were 271 incidents, 236 in June and 282 in July with the majority of incidents occurring on Redgrave ward. This was however a decrease in incidents compared to our last inspection in April 2021.

Reporting incidents and learning from when things go wrong

- Staff did not always report incidents clearly via patient clinical notes or incident reporting systems. For one incident which we reviewed, we found that staff did not clearly document how a patient was able to ingest foreign objects whist on constant staff observations. Staff also failed to accurately report rationales for decision making and failed to accurately record a clear timeline of events. The reporting of the incident via the provider's statutory reporting to CQC

also failed to highlight the use of handcuffs on the patient, how staff removed an object used to self-harm and did not accurately detail the patient's physical condition following self-harming. Another incident which we reviewed did not highlight that staff used soft handcuffs on the patient or detail attempts to de-escalate the patient prior to using handcuffs. Staff failing to report incidents accurately and clearly was a concern found during a previous inspection of this service.

- Managers had not acted to prevent patient safety incidents from occurring again. We raised concerns relating to various patient safety incidents during this inspection which we also found at our previous inspections of the service. For example, during this inspection and past inspections, we found that staff were not responding appropriately to patients who were self-harming, resulting in injuries to the patients. This demonstrated a lack of improvement in response to patient safety incidents and not learning from when things went wrong. We requested that managers reviewed incidents we had identified during this inspection that required an assessment of injury to the patient and a review of the patients care needs.
- Managers did not review all incidents within two to seven days of reporting in line with the provider's 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 nor did the reviews always identify areas of concern that warranted further investigation.
- 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. Managers also shared learning in emails to staff. However, lessons learned bulletins appeared to be copied and pasted sections of the brief management review from the incident reporting system without reference to the specific incident. Without the context of the incident, the learning points were not relevant in order for staff to relate them to a patient or a specific type of incident. Learning points were also often repetitive and lacked detail, such as 'staff to offer support to the patient', without describing the incident or the type of support.
- Managers did not highlight learning points to staff in a timely way following incidents. For example, managers failed to identify that staff failed to respond to potentially serious patient safety concerns with two out of 17 incidents which we reviewed and therefore had not shared feedback or learning to staff involved. This risked the incident occurring again and further harm to patients.
- Managers provided an explanation to patients when things went wrong in three incidents which we reviewed. This was an improvement since our last inspection.
- Staff attended handover meetings however handover meeting notes were very brief and lacked detail. For example, staff would not always include details of recent incidents, instead they would refer staff to look at the incident reporting system. This could result in staff not being aware of any recent changes to patient risk. However, on Walsham, Waveney and Redgrave wards, a night-time nurse wrote an operational briefing report which summarised how each patient had presented over a two-day period.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S31 Urgent variation of a condition