Care Quality Commission

Kneesworth House

Quality Report

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

Overall summary

We did not rate forensic/secure wards or psychiatric intensive care units (PICU) at this focused inspection.

We found the following issues that the provider needs to improve:

- Wimpole Ward, the psychiatric intensive care unit (PICU), was unsafe. Staff reported high levels of aggression between patients and on staff. Some incidents involved several patients joining together to attack their peers. Managers had failed to provide staff with appropriate guidance on how to deal with these incidents or to learn lessons from them. Managers had not ensured staff working on the PICU had specific training to equip them for this and so were not adequately prepared to work with the specific patient group.
- Staff did not effectively manage patient risk. Staff had failed to identify individual patient risks or strategies to manage the risks on Orwell Ward or on Wimpole ward (the PICU). Staff on the PICU had not fully completed risk formulation for patients and staff had not updated risk assessments after incidents.
- Managers had not described or identified potential ligature points in the wards' ligature risk audits or how staff should mitigate the risk. Staff did not have access to the most up-to-date printed ligature risk audits.
- The PICU was dirty and poorly maintained. Sink wastes needed replacing in toilets and bathrooms and a toilet door was missing. The kitchen and dining room areas had loose and engrained dirt in the floors, under tables and in drawers.
- Managers had not ensured there were enough staff to maintain the safety of patients and facilitate patient leave consistently. This was more evident on wards designed over two floors.
- Seclusion practices, including the recording of seclusion and the storage of records were not in line with the requirements of the Mental Health Act Code of Practice.
- Staff kept food at high temperatures in the kitchen on Wimpole ward which could pose a risk to patients.

However, we found the following areas of good practice:

- Staff offered practical and emotional support where needed. Seven of the 12 patients we spoke with told us staff were understanding, helpful and polite and cared about their wellbeing.

Summary of findings

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Care Quality Commission

Kneesworth House

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards

Summary of this inspection

Background to Kneesworth House

Kneesworth House is part of the Priory Group of companies. It provides inpatient care for people with acute mental health problems, a psychiatric intensive care unit (PICU), locked and open rehabilitation services, including some patients with a learning disability, and medium and low secure forensic services for people with enduring mental health problems.

The Care Quality Commission last completed a comprehensive inspection of this location between 19 February and 4 April 2019. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. Requirement notices were issues under the following regulations:

- Regulation 9 – Person-centred care
- Regulation 10 – Dignity and respect
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15 – Premises and equipment
- Regulation 17 – Good governance
- Regulation 18 – Staffing

The overall rating for this location was inadequate, with inadequate in the safe domain, good for effective, inadequate for caring, good for responsive and inadequate for well-led. The report for this inspection had not been published at the time of this inspection.

At this focused inspection we found further breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for regulations 12 (safe care and treatment), 17 (good governance) and 18 (staffing). We imposed conditions on the provider's registration at this location, under Section 31 of the Health and Social Care Act 2008. Since this inspection, the provider has sent the CQC information outlining how they will be reviewing and addressing breaches of Regulation 12, safe care and treatment, Regulation 17, good governance and Regulation 18, staffing, relating to the conditions. These conditions were removed on 18 February 2020.

The service is registered to provide the following regulated activities:

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

The hospital had 140 beds. Since the last inspection, the provider had closed Icknield ward, a 16-bed low secure service for men with a mental illness and learning disability.

We inspected the following core services:

Forensic inpatient/secure wards

- Clopton - 15 bed medium secure service for men with a personality disorder.
- Ermine - 19 bed medium secure service for men with a mental illness.
- Orwell - 18 bed low secure service for men with a mental illness.

Psychiatric intensive care unit

Wimpole ward – 12-bed service for women with a mental illness.

Our inspection team

The team that inspected the service comprised three CQC inspectors, two CQC inspection managers, one Mental Health Act reviewer, one assistant inspector and one expert by experience.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection due to concerns raised by the previous comprehensive inspection. During the inspection, the inspection team decided to inspect the newly opened psychiatric intensive care unit (PICU) because of staff reports about the acuity of the ward and the high level of incidents reported by the ward.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 15 patients who were using the service;
- spoke with the registered manager, core service managers and managers or acting managers for each of the wards;
- spoke with 20 other staff members; including doctors, nurses, therapy assistants;
- looked at 12 care and treatment records of patients;
- looked at 12 seclusion records;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We interviewed 15 patients across the hospital. Seven of the 12 patients we spoke with on the forensic wards told us staff were understanding and cared about their wellbeing. One patient stated that there were not enough staff and that too many staff were taken from the ward to cover the PICU. Another said he did not like female patients being secluded in Clopton ward's seclusion room, which happened on a regular basis. Others said staff spent too long in the office and not enough time on the ward and that there was often little to do, and that therapy suffered due to the lack of cover for psychology staff. Three patients felt staff could have been more supportive and helpful in some circumstances.

We spoke with three patients on Wimpole ward (PICU). Two patients told us they did not feel safe and that there were not enough staff. All the patients we spoke with said the environment was poor; two said the ward was dirty, particularly the floors and sinks. One patient told us they did not know who the staff were as the noticeboard, stating which staff were on duty, was not used.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the provider needs to improve:

- Wimpole Ward, the psychiatric intensive care unit (PICU), was unsafe. Staff had reported high levels of aggression between patients and on staff. Some incidents involved several patients joining together to attack their peers. Managers had failed to provide staff with sufficient or appropriate guidance on how to deal with these incidents or to learn lessons from them. Risk assessments on the PICU were not robust. Staff had not fully completed risk formulation for patients. and staff had not updated risk assessments after incidents.
- Staff did not effectively manage patient risk. Staff had failed to identify individual patient risks or strategies to manage the risks on Orwell and Wimpole wards.
- Managers had not ensured there were enough staff to maintain the safety of patients and facilitate patient leave consistently. This was more evident on wards which were designed over two floors.
- Managers had not described or identified potential ligature points in the wards' ligature risk audits or how staff should mitigate the risk.
- The PICU was dirty and poorly maintained. Sink wastes needed replacing in toilets and bathrooms, and a toilet door was missing. The kitchen and dining room areas had loose and engrained dirt in the floors, under tables and in drawers.
- Staff's seclusion practices including the recording of seclusion and the storage of records were not in line with the Mental Health Act Code of Practice.
- Food was kept at high temperatures in the kitchen on Wimpole ward which could pose a risk to patients.

Are services caring?

We found the following areas of good practice:

- The practice of staff prodding patients' feet to get them up in the morning, that we discovered on Icknield ward at the last inspection, was not replicated on any of the other wards we inspected. The service had closed Icknield ward since our last inspection. There was no evidence that staff tried to support patients inappropriately or treated them in ways they did not like.
- We observed staff interacting with patients, offering practical and emotional support where needed.

- Staff were not using institutional practices to manage the ward. Patients and staff confirmed that access to bedrooms had increased and that patients were not required to remain in upstairs or downstairs areas at certain times.
- Seven of the 12 patients we spoke with told us staff were understanding, helpful and polite and cared about their wellbeing.

However, we found the following issues that the provider needs to improve:

- Three patients felt that staff could have been more supportive in some circumstances.

Are services well-led?

We found the following issues that the provider needs to improve:

- Managers had not ensured there were enough staff to maintain the safety of patients and facilitate patient leave consistently. Managers did not have enough staff on the wards for patients to utilise their section 17 leave consistently.
- Managers did not have robust systems in place to monitor the effectiveness of patients' risk assessments. Staff had not completed risk assessments fully or after incidents, therefore managers were not assured that patients risks were managed safely and effectively.
- Managers had not described or identified potential ligature points in the wards' ligature risk audits or how staff should mitigate the risk.
- Managers had not provided staff with the most up to date printed copy of ligature risk assessments. We were not assured that staff were fully aware of the identified risk and could mitigate them to keep patients safe.
- Managers had not maintained oversight of the environmental issues on the PICU and were therefore unaware of the issues of uncleanliness.
- Managers had not ensured staff on Wimpole ward had PICU specific training and were adequately prepared to work with patients within the service.

Acute wards for adults of working age and psychiatric intensive care units

Safe	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment

- Wimpole ward was opened in April 2019 and catered for up to twelve patients. Bedrooms were not en-suite and patients had to share toilet and shower facilities.
- Wimpole ward was extremely dirty and presented infection control risks. During the inspection on Monday 24 June 2019, the communal day area was visibly dirty. We saw paint spillages on the floor, spilt drinks that staff had not cleaned, and loose and ingrained dirt on the floor. The laundry room had ingrained and loose dirt, including some dead insects, and a significant spillage of washing powder on the floor which was a slip-trip hazard. The dining room was visibly dirty and we found debris in the corners of the room. The undersides of the dining tables were sticky with food debris which posed an infection control risk as several of the patients had wounds from episodes of self-harm. A store cupboard for patient belongings which was not accessed by patients on a regular basis, was extremely dusty and dirty.
- Staff had not replaced the door to one toilet after it was damaged and had not put up a sign to indicate it should not be used. Therefore, staff could not maintain the privacy and dignity of patients using this toilet. There was no signage on toilet, bathroom and shower rooms to indicate their function. To address this, a patient had made colourful signs and stuck them on some of the doors. In the bathrooms and toilets, we saw soap scum and limescale in plug holes, around taps and in toilet bowls and drains. The shower drains in the floor had rusted and needed replacing. We raised these issues with the nurse showing us around and separately with the Hospital Director who indicated he would ensure this would be addressed that day.
- We reviewed incident forms and found a form completed by housekeeping staff that hygiene standards in the seclusion room were poor. Housekeepers reported that they found the mattress was soaked in urine, towels were stained, faeces were on the floor and walls and the room contained food debris such as egg shells.
- Cleanliness of the ward areas we had identified had not significantly improved when we inspected on 25 June 2019 with the Hospital Director and other staff. The floor in the communal area still had visible stains. We asked to see the laundry room which still had dead insects and washing powder on the floor. The dining room appeared slightly cleaner, however the underside of the tables were still sticky. Privacy and dignity of patients remained compromised as the toilet door had not been replaced. Managers told us they had not replaced the toilet door because the hospital did not have a stock of doors and would need to order this item.
- We inspected the kitchen on 25 June 2019 as we had not been able to do this on the previous day. We found issues with food storage, temperature control and cleanliness. The kitchen was very hot. The floor was heavily stained and dirty. The soap dispenser at the hand washing sink was empty and the electric hand dryer next to the sink was not working. We opened drawers and cupboards, all of which were heavily stained and contained debris. We found food bags had been left in the chilled food trolley and a tray of yoghurts on the top shelf of the trolley. When we tested the temperature with a probe, the food bags ranged from 27 degrees to 29 degrees Celsius. The yoghurts were 38 degrees Celsius. We were told this was 'left over food' but there was no signage to indicate that the food was not to be used and was for disposal. We were therefore not assured that this food would not be given to patients.
- Patients told us the environment was poor. We interviewed three patients. All the patients we spoke with told us they did not like the environment. Two patients told us the ward was dirty; one of these told us there were dead flies in the bedrooms and that sinks in the bathrooms were dirty, had limescale and were often blocked.
- Staff did not have easy access to ligature risk assessments. Ligature is the term used to describe a

place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. On 24 June, we asked to see the ligature audit. Staff took approximately five minutes to locate this. The audit identified bedroom areas, but did not cover the day room, garden, corridors, bathrooms all of which had significant ligature points. When we reviewed the audit on 25 June, a different folder was produced which contained ligature risks across the whole ward including communal and garden areas. Managers told us that there were two ligature audit files, but many staff did not know this. All staff had access to the electronic version. All the staff we spoke with said they would use the paper version as it was easier. The electronic audits had been reviewed on 1 April 2019, but printed copies were dated 13 March 2019. Staff were therefore not using the most up-to-date version.

Safe staffing

- We visited Wimpole ward (PICU) on 24 and 25 June 2019. On 24 June, there were nine staff on duty to support eight patients. This matched the rota for that day. We attempted to speak with staff but found that the ward was chaotic, and staff were not available to speak with us due to the high acuity of the patient group. On 25 June, there were nine patients and eight staff on duty, including for four patients on enhanced observations. The ward was again very busy and we were unable to speak at length with staff. Use of bank and agency staff was high on these days. We were not assured that there were sufficient staff to support patients safely.

Assessing and managing risk to patients and staff

- Patients did not have adequate risk assessments, risk formulations or risk management plans in place to enable staff to manage patients. We reviewed risk assessments and care records for all eight patients. Risk assessments only had a formulation in place for one patient. There was some risk information contained in some of the '72-hour care plans' and the 'keeping safe care plans', but this was limited, generic in nature, contained no formulation and no plans to manage identified risks.
- Risk assessments were not always completed on admission and not updated consistently after incidents. One patient had a brief risk assessment completed on admission but had no formulation or risk management plan. Staff updated this after a serious incident involving a number of patients. Staff did not update risk assessments following 14 further incidents, including self-harm and violence to staff. Care plans contained some information about risk and details of challenging behaviour but there was no risk formulation or plan to manage them safely. Another patient had no risk assessment in place. Records stated that staff should observe risk indicators, so a formulation could be written, but there was no formulation of risk or risk management plan in care plans. Staff had identified some general interventions, for example, using low stimulation areas and as required medication, but there was little detail regarding how to manage these interventions. Another patient was identified as presenting high risks to staff and had significant health issues. However, there was no risk formulation, no risk management plan and limited evidence of any physical health screening.
- We looked at six seclusion records on Wimpole ward (PICU). In five records, staff had not kept paperwork in chronological order, making it difficult to read. Most records were in piles or in boxes and different patients' notes were mixed up. In two records, there was no record of when the seclusion ended, and seclusion care plans were minimal. Nursing and medical reviews did not meet the criteria for the Mental Health Act Code of Practice in four of the six records we looked at. Some nursing reviews were missing. For example, one patient had no nursing review from 8am to 8pm on one day and from 12pm to 8pm on another.Some reviews were completed with only one nurse attending, and others where nurses did not sign or put 'as above'. Medical reviews were also inconsistent. One patient missed a multidisciplinary team review; another patient was secluded for 13 days and only saw the consultant psychiatrist four times during that time. Reviews generally planned to end the seclusion as soon as possible. However, we saw that staff recorded that patients were calm, with no rationale as to why seclusion was not terminated.
- Incidents were frequent, dangerous and were not well managed. Between 1 May and 25 June, there were 359 incidents reported on the ward. The majority of these were reports of patients attacking other patients. When we visited on 24 and 25 June 2019, we saw incidents involving up to six patients, hair pulling, spitting, kicking

and punching in the face. Incidents indicated extremely high levels of fights between patients, physical aggression towards staff and self-harming behaviour, including persistent head banging and tying ligatures which required cutting. In one incident, a nurse had drawn up an injection to give a patient in their bedroom and placed it on the patients' chest of drawers. The patient had grabbed the syringe and threatened to stab staff with it. Additional staff were frequently sought from other wards and noted to be slow to arrive on occasions.

Safeguarding

- There were high levels of incidents and safeguarding referrals from this ward. The CQC has worked with the local authority and the provider to consider how this had been managed, what action had been taken and what further action is needed, if and when patient numbers increase.

Reporting incidents and learning from when things go wrong

- There was a high level of incident reporting, particularly incidents involving several patients in aggressive and violent behaviour. We saw no evidence of learning taking place as a result of these incidents.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Culture

- Staff we spoke with were positive about the work they were doing with patients and proud to work on the ward.
- Managers did not always deal with poor performance effectively. We looked at a safeguarding concern identified at the last inspection. We saw that the provider had undertaken an investigation in relation to two members of staff. However, the provider had not properly assured themselves that the issues identified had been explored and that adequate monitoring had taken place after the disciplinary process had concluded. Managers had offered supervision but had not addressed the concerns and stipulations that the provider had themselves laid down.

Governance

- Managers had not maintained an oversight of the physical condition of the ward and ensured that issues were dealt with promptly and effectively. The ward was dirty and poorly maintained despite having been open for only two months prior to the inspection. There were issues in regard to cleaning, particularly when cleaners were unable to perform their duties due to incidents taking place on the ward. There were also maintenance issues caused by faulty equipment and poor quality of some aspects of the environment, such as sinks, taps and toilets. There were infection control risks to patients and staff which managers had not identified or addressed.

Management of risk, issues and performance

- Managers had not ensured that staff had received adequate preparation and training to work in a PICU. Some staff had attended a two-week induction to the new service.
- Managers had not ensured that staff had easy access to accurate and comprehensive ligature risk assessments. The ligature risk audit did not identify or describe all ligature risks and how to mitigate them. When ligature audits were completed the most up-to-date version was uploaded electronically but the printed copy used by most ward staff was not updated.
- Managers had not ensured that risk assessments and risk management plans were in place for patients on the PICU. This had not been identified and addressed at ward or senior level and had led to staff not having the knowledge and strategies to minimise risk, manage incidents and keep patients safe. The process to admit patients in line with their admissions policy, to acknowledge the importance of the mix of patient presentation, levels of patient need and the knowledge of the staff group to manage patient risk, was not robust. This led to high levels of incidents involving several patients and a lack of direction to staff about how to manage patient risks.

Forensic inpatient or secure wards

Safe	
Caring	
Well-led	

Are forensic inpatient or secure wards safe?

Safe and clean environment

- Managers had not ensured that paper copies of ligature audits were up to date. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Ligature audits were also available in electronic format. Staff we spoke with about this said they used the printed copies as this was easier and they could not always have access to a computer. Whilst the electronic ligature audits were in date, the paper copies on Ermine and Orwell wards were not the most recent version. Most paper copies of these audits were dated October or November 2017. On Orwell ward the paper copy of the ligature audit we looked at was 7 June 2017. We were not assured that staff were aware of all the ligature audits identified for both wards.
- On Ermine ward, a patient had damaged one of the metal telephones in the telephone booths on the ward. Staff had temporarily replaced this with a plastic phone with a cord in excess of 10 feet. The phone was not fixed to the wall and could be removed and potentially used by patients to harm themselves or others. We raised this with the provider at the time of the inspection and they removed it immediately. We looked at the ligature audit for the telephone booths which were located in the main communal area of the ward. The audit did not describe the risk but stated the risk was mitigated by its position in a high traffic area and visible at all times.

Safe staffing

- Managers had not ensured there were enough staff to maintain the safety of patients at all times or allow patients access to therapeutic activities including Section 17 leave. Wards had the numbers and grades of staff allocated to that ward on the rota for the day shift. The provider used the Priory's staffing ladder to determine how many staff to allocate to each ward. We reviewed staffing numbers on Sunday 23 June for Clopton, Ermine and Orwell wards. The hospital allocated two-hour breaks for staff so actual staffing numbers on the wards were generally one less than on the rota. We observed this on our visit. Staff told us that they usually had their allocated breaks although there were some occasions when this was not possible due to staff shortages across the hospital. Staff told us that one member of staff was identified as a 'runner' and was required to be available to go to other wards when needed. Staff confirmed that happened on a regular basis.
- Managers had not structured staffing levels in line with acuity and clinical need, and there were insufficient staff to manage patients safely. Ermine and Orwell wards were over two levels, with bedrooms and some communal areas upstairs and the majority of the communal areas downstairs. On Orwell ward there were 18 patients and seven staff on duty, including two registered nurses and one member of staff for enhanced observations. Staff told us that due to patients having access to both upstairs and downstairs areas, the ward often only had one member of staff upstairs and one downstairs to supervise patients. We observed this practice on our inspection. Staff told us that this made it very difficult to ensure patient safety. Staff told us that they were frightened to come to work and felt the ward was unsafe. Day staff were concerned about handing over to night staff which had five planned staff.
- On Ermine ward there were 16 patients. Staffing numbers had recently reduced from eight staff on the day shift to six, because one patient had been allocated enhanced observations. On 23 June, there were two registered nurses and five healthcare workers, including one member of staff for enhanced observations. Staff told us that working over two floors meant that they were extremely stretched, particularly as one staff was usually on their break at all times. Six staff said

supporting patients over both floors with the current staffing allocation meant managers did not always allocate two members of staff upstairs to supervise patients.

- On Clopton ward there were 14 patients. Staffing consisted of two registered nurses and four healthcare workers.
- Patients could not always access escorted leave. Doctors had to assess that leave could be accommodated and not just that it was safe. Across Ermine and Orwell wards, 11 staff we spoke with told us that there were not enough staff to escort patients on agreed section 17 leave.
- We raised staffing issues with the provider following the inspection. The provider raised staffing on Ermine ward from six to eight staff plus staffing for patients on observations. Staffing on Orwell ward was increased from five to six staff plus staffing for patients on observations.

Assessing and managing risk to patients and staff

- In the last inspection report, published on 30 July 2019, we reported that, in the forensic/secure wards, staff did not seclude patients in line with the requirements of the provider's policy and the Mental Health Act Code of Practice. Some medical and nursing reviews had not been completed within timescales, seclusion care plans were poorly recorded and in three examples of prolonged seclusion, staff did not make it clear why seclusion needed to continue.
- At this inspection, we reviewed six further seclusion records in this service. These did not always comply with the Mental Health Act Code of Practice. We found that medical reviews did not take place in two of the records and staff had not completed seclusion care plans in any of the records we reviewed.
- Staff had stopped using blanket restrictions or institutional practices to manage wards over two floors since the last inspection. Patients could access all parts of the ward throughout the day. On Ermine ward, patients were asked and encouraged to remain upstairs between 15:00 and 16:45 so staff could have 'protected time' to complete paperwork. However, patients wishing to remain downstairs were allowed to do so.
- There were insufficient staff on Orwell ward to conduct patient searches consistently after leave. Staff we spoke with told us staffing numbers and the lack of an appropriate room meant that patients were frequently not searched on returning from leave. We observed patients take unescorted leave from Orwell ward on Sunday 23 June and none were searched. Staff on Ermine ward told us all patients on unescorted leave were searched on return. Staff told us this only applied to one patient at the time of the inspection. Staff on Ermine and Orwell said that they sometimes intercepted tobacco or drugs but were not generally aware how it was getting onto the wards. Contraband was continuing to enter the wards.
- The provider did not effectively manage the risk to patients. We reviewed a recent incident between two patients on Orwell ward. One patient had attacked and injured another patient while on unescorted leave. This had caused the ward to become tense and unsettled. The victim of the assault was placed on enhanced observations. However, managers did not increase observation levels for the assailant. We reviewed patient records for the two patients. The provider placed them on the same ward despite having a history of significant altercations. Managers making this decision had not consulted the wider multidisciplinary team or reviewed the patients' medical records and were therefore not aware of this. Staff who did know about this were not involved in this decision.

Safeguarding

- Managers had taken disciplinary action against a member of staff when a safeguarding alert had been raised.

Are forensic inpatient or secure wards caring?

Kindness, privacy, dignity, respect, compassion and support

- We inspected the forensic/secure wards on 23-24 June 2019 and interviewed 12 patients.
- We observed staff interacting with patients, offering practical and emotional support where needed. We did not find any evidence that staff were supporting patients in an overbearing or antagonistic way.
- At the last inspection, in March 2019, we were concerned that some staff on Icknield ward used abusive practices to get patients up in the morning. We spoke to nine patients. Patients confirmed there were no set rising and bedtimes. There was no evidence that staff tried to

support patients inappropriately or treated them in ways they did not like. There was no evidence that the practices we discovered on Icknield ward were replicated on any of the other wards we looked at. The provider had closed Icknield ward at the time of the inspection.

- Patients and staff confirmed that access to bedrooms had increased and that staff were not required to remain in upstairs or downstairs areas at certain times. Patients were encouraged to remain upstairs on Ermine ward immediately prior to dinner time to facilitate protected time for staff but this was no longer a requirement.
- Seven of the 12 patients we spoke with told us staff were understanding, helpful and polite and cared about their wellbeing. They told us things had improved since they were allowed access to their bedrooms when they wanted. Three patients felt that staff could have been more supportive in some circumstances.

Are forensic inpatient or secure wards well-led?

Governance

- Managers had not ensured there were enough staff to maintain the safety of patients and facilitate patient leave and therapeutic activity consistently on Ermine and Orwell wards. Whilst managers used the Priory's staffing ladder to determine how many staff to allocate to each ward, we were not assured of the effectiveness of this process. Managers had not structured staffing levels to ensure that the number of staff met the patients' needs. The staffing ladder did not take into account the amount of staff needed to manage patients on wards that had two floors.

Management of risk, issues and performance

- Although managers had completed ligature audits, they did not accurately describe the risks and how to mitigate them. Managers had updated ligature audits electronically but had not replaced the printed copies on the ward which most staff referred to when needed. Therefore, the provider was not assured that staff were fully aware of the ligature risk posed to patients.
- Managers had not ensured that patient risk was properly managed and recorded and that action was taken when needed. Managers had replaced one of the patient telephones on Ermine ward with a removable telephone that patients could use to harm themselves.
- The provider had investigated the incident on Icknield ward in relation to two members of staff. However, managers monitoring and managing staff after the investigation, did not meet the requirements that the provider had documented and did not assure the provider that appropriate learning had taken place.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they undertake a review of cleaning and infection control practices, including the cleaning schedules at the PICU, to ensure that this is sufficient to ensure the care environments are clean and odour free.
- The registered provider must undertake a review of the environment of the PICU to include ligature risks within the ward and service users' privacy, dignity and safety from risk when in their bedrooms.
- The registered provider must undertake a review of the environment of the PICU to ensure dining room and bedroom floors, taps and waste traps are in good condition and replaced where appropriate, and that the environment is well maintained.
- The provider must ensure that all patients have a risk assessment in place which identifies patients' risks, enables staff to manage those risks and is updated after incidents.
- The provider must ensure that there is a review of staffing on the PICU to assure themselves the staff on the PICU are suitably qualified and competent to carry out their roles in a PICU environment and are trained in the identification and management of clinical risk.
- The provider must ensure that there are sufficient staff, who are experienced and appropriately trained to ensure a safe and therapeutic environment for patients.
- The provider must ensure that seclusion is carried out in line with the requirements of the Mental Health Act Code of Practice and that records are completed and stored appropriately.

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 **The provider had not ensured that seclusion was carried out in line with the requirements of the Mental Health Act Code of Practice and that records were completed and stored appropriately.**

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Following this inspection we imposed urgent conditions on the provider in respect of this regulation. After further inspections to review the improvements made by the provider, these conditions were removed on 18 February 2020.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Following this inspection we imposed urgent conditions on the provider in respect of this regulation. After further inspections to review the improvements made by the provider, these conditions were removed on 18 February 2020.

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 Following this inspection we imposed urgent conditions on the provider in respect of this regulation. After further inspections to review the improvements made by the provider, these conditions were removed on 18 February 2020.