Kneesworth House

Quality Report

Kneesworth House Hospital
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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 psychiatric intensive care units (PICU) at this focused inspection.

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

- While risk assessments had improved, staff did not manage patient risk consistently. Staff did not always update risk assessments after incidents. Managers were not assured that patients' risks were always managed safely and effectively.
- Managers had not ensured staff had PICU specific training and were adequately prepared to work with patients within the service.
- Managers had not described or identified all 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 provider had not addressed all environmental concerns in their action plan and some actions were overdue. Sink wastes needed replacing in toilets, bathrooms and bedrooms. The kitchen had loose and ingrained dirt in the floor and under the fridge.
- The chilled food cabinet was not working correctly and recording high temperatures. Staff had not checked the temperature of this equipment.

However, we found the following areas of good practice:

- The ward was visibly cleaner than at the last inspection visit.
- Risk assessments on the PICU were of a higher quality and contained more detail than at the last inspection.
- Managers had overseen some improvements to the PICU's environment. We noted that the ward was cleaner, staff had replaced the toilet door and put up signs for toilets and bathrooms and had ordered new floors and sink wastes.

Summary of findings

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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, 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, including some patients with a learning disability.

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 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.

We inspected the following core services:

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 one CQC inspector and two CQC inspection managers.

Why we carried out this inspection

We carried out a focused inspection in June 2019 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.

At the focused inspection in June 2019 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.

This inspection was a follow up to the focused inspection in June 2019 to see what improvements had been made against the enforcement action we took at the June 2019 inspection.

Summary of this inspection

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 the psychiatric intensive care unit (Wimpole ward), looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with the registered manager, core service manager and manager or acting managers for the ward;
- spoke with seven other staff members; including nurses, healthcare assistants, therapy assistants;
- looked at seven care and treatment records of patients and;
- 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 did not speak with any patients during this inspection.

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:

- Managers had not identified all potential ligature points in the wards ligature risk audit or how staff should mitigate the risk. Managers had reviewed the ligature audit but had not updated the printed copy used by staff.
- Risk assessments and risk formulations had improved but were inconsistent.
- The provider had not addressed all environmental concerns in their action plan and some actions were overdue. Sink wastes needed replacing in toilets, bathrooms and bedrooms. The kitchen and dining room areas had loose and engrained dirt in the floors and under the fridge.
- The chilled food cabinet was not working correctly, and staff did not check the temperature regularly.

However, we found the following areas of good practice:

- The ward was visibly cleaner.
- Patient risk assessments on the PICU contained more detail than at the previous inspection in June 2019.

Are services well-led?

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

- 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 risks and could mitigate them to keep patients safe.
- Managers had not ensured staff had PICU specific training and were adequately prepared to work with patients within the service.
- It was not clear that staffing numbers were robust enough to support more patients should the provider accept additional referrals.
- While managers had put systems in place to monitor the effectiveness of patients' risk assessments, the quality of risk assessments was inconsistent. Risk assessments were not always updated after incidents. Therefore, managers were not assured that patients' risks were always managed safely and effectively.

Summary of this inspection

However, we found the following areas of good practice:

- Managers had overseen some improvements to the PICU's environment. We noted that the ward was cleaner, staff had replaced the toilet door and put up signs for toilets and bathrooms and had ordered new floors and sink wastes.

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.
- When we visited in June 2019, the PICU was dirty and poorly maintained. Sink wastes needed replacing in toilets and bathrooms, there were no signs on the toilet or bathroom doors and a toilet door was missing. The kitchen and dining room areas had loose and ingrained dirt in the floors, under tables and in drawers. In the kitchen, we found food bags, 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 and the yoghurts 38 degrees Celsius.
- While the provider had resolved some environmental issued when we inspected again on 1 August 2019, we still had concerns. The sink, shower and bath drains remained chipped and rusty. The provider sent us an action plan that this work was due to be completed on the 31 July 2019. Some, but not all, of the breaks in the dining room floor had been filled, and we were not assured that this did not prevent the spread of bacteria and potential risks for patients. However, managers told us they had ordered new floor coverings. In one of the toilets, there was a blockage in one of the sinks and a broken window which staff had not reported. There were paint marks on some of the worktops which staff had not cleaned. We raised these issues with staff who said they would report them to the maintenance team.
- However, we were pleased to see that the communal areas were much cleaner, the toilet door had been replaced and there were signs on the toilets, bathrooms and shower rooms. The kitchen and dining room areas were both cleaner than when inspected on 25 June. Fridge temperatures were within the acceptable range and staff checked these regularly. However, the kitchen floor had some ingrained dirt which did come away when we cleaned it. We found loose dirt and an insect under the fridge. The black mastic, sticking the floor covering to the wall, had come away and had collected loose dirt. The chilled food trolley was not working correctly. Staff told us it should keep food at 8 degrees Celsius or less. When we entered the kitchen, it was reading 14.9 degrees and 19 degrees when we left. We raised these issues with the provider. Staff confirmed that there was no system in place to check the temperature of the trolley. Staff told us that they kept sandwiches in the fridge. However, if patient levels were to rise, this would be more difficult due to the size of the fridge.
- Housekeeping staff told us that they could not attend the ward if an incident was taking place. The high level of incidents during May and June meant that for long periods, they were unable to clean the ward and nursing staff were not available to complete these tasks.
- When we visited in June 2019, staff did not have easy access to up-to-date 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. The ligature audit identified bedroom areas, but did not cover the day room, garden, corridors, bathrooms all of which had significant ligature points. We were told there were two ligature audit files, but many staff did not know this. The second file covered all other areas of the ward. 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.
- We reviewed the ligature audit again on 1 August 2019. The courtyard ligature audit only addressed risks to the fencing and walls, for example, we observed an open window in the courtyard which could be used as a ligature point and a flowerpot which patients could stand on to reach it, which were not identified on the audit. Managers had completed an audit of ligature risks electronically but had not replaced the printed version

in the file used by staff on the ward. Three staff we spoke with told us they used the printed version of the ligature audit as it was easier to access. One member of staff told us they were unaware of the audit.

Safe staffing

- When we visited in June, we were not assured that there were sufficient staff to support patients safely. On 1 August 2019, there were four nursing staff on duty for three patients, which was an improvement on the previous inspection. Core staffing was three members of staff, plus one additional staff for a patient on enhanced observations. Throughout the day, additional staff were brought in from other wards to manage patients when needed.
- We spoke with the four members of staff on duty. None of the staff we spoke with had received any additional training since our previous visit. Staff who attended the two-week induction programme prior to the ward opening said some sessions were cancelled due to staffing shortages on other wards.
- There were four members of staff who had limited experience of working in a PICU setting. These staff offered some support to the staff team within their capabilities. Three of these were agency staff.

Assessing and managing risk to patients and staff

- When we visited in June 2019, patients did not have adequate risk assessments, risk formulations or risk management plans in place to enable staff to manage patients. Risk assessments were not always completed on admission and not updated consistently after incidents. Incidents were frequent, dangerous and were not well managed. Most were reports of patients attacking other patients.
- Risk assessments had improved when we inspected on 1 August 2019, but this was inconsistent. There were three patients when we inspected. Numbers of incidents had reduced markedly as patient numbers had reduced. We looked at risk assessments for the three patients. Risk formulations were generally present and contained information about previous risk presentation or recent incidents. Risk assessments were often updated after incidents and incidents were often recorded in case notes and discussed in ward round. However, this practice was not consistent. We found one risk assessment that did not highlight all the patients' risks and some risk assessments that were not updated after incidents. Staff did not always record significant incidents in case notes or discuss them in ward round. We also found an example of a risk assessment stating there was no risk of self-harm after an incident of self-harming behaviour.
- Risk assessments on the acute admission ward were completed on admission but were inconsistent in quality. On 1 August, we also looked at the admissions process on Bourn ward, as we could not assess this on the PICU as the provider had not admitted new patients since the last inspection. We looked at four patient records. Risk formulations were completed in three of the four initial risk assessments. Where this was missing, staff completed a formulation 11 days later, when the risk assessment was updated. Risk formulations were copied from ward round notes or admission notes. Risk assessments identified all the patients' risk although in one record, this lacked detail.
- Staff we spoke with said that the patient mix led to friction and aggression on the ward. The service admitted patients with emotionally unstable personality disorder and patients with a mental illness, such as bipolar disorder or schizophrenia.

Safeguarding

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

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

Governance

- When we inspected in June, managers had not maintained an oversight of the physical condition of the PICU and ensured that issues were dealt with promptly and effectively.
- The provider had not addressed all the issues we raised at the June 2019 inspection when we inspected on 1 August 2019. The dining room floor, and floors in the toilets and bathroom areas were on order but had not

been replaced as detailed in the provider's action plan. The ward was noticeably cleaner, but there were still some issues in relation to the kitchen area which required attention.

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. However, some staff told us some sessions had to be cancelled and they did not feel it prepared them for what followed. Staff brought in after the opening of the ward had not received any PICU specific training to work on the ward.
- 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. Managers had updated and uploaded ligature audits electronically. However, they had not updated the printed copy used by most ward staff.
- When we inspected in June 2019, managers had not ensured that risk assessments and risk management plans were in place for patients on the PICU. Managers had ensured some improvements had been made when we inspected on 1 August 2019. Risk formulation and risk assessments were more robust and contained more information to enable staff to manage patient risk. However, patient records for admissions were inconsistent on the acute ward and it was not possible to look at new admissions to the PICU.
- While staffing numbers on the inspection supported patients most of the time, the provider had to bring in additional staff throughout the day to manage patients. Given the acute levels of need for patients in PICU services, we were not assured at this inspection, that the unit would be able to operate effectively with additional admissions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that actions identified in their action plan in relation to the environment on Wimpole ward are completed within the timescales identified.
- The provider must 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 there are sufficient staff, who are experienced and appropriately trained to ensure a safe and therapeutic environment for patients.