# South West London and St George's Mental Health NHS Trust

## Quality Report

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| Core services inspected | CQC registered location | CQC location ID |
|---|---|---|
| Wards for older people with mental health problems | Tolworth Hospital<br>Springfield University Hospital | RQY08<br>RQY01 |
| Acute wards for adults of working age and psychiatric intensive care units | Tolworth Hospital<br>Springfield University Hospital<br>Queen Mary's Hospital | RQY08<br>RQY01<br>RQY07 |

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

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

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

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

# Summary of findings

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## Overall summary

In the acute wards for adults of working age and psychiatric intensive care units we found that:

- Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely.
- On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans.
- On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not always recorded or reviewed.
- Some equipment on Lilacs and Lavender wards was not maintained on a regular basis to ensure it was fit for purpose.
- On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients needs, and did not reflect their preferences. Many patients were not involved with the development of care plans.
- Staff on Lilacs ward in particular lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent and did not understand their legal responsibilities.
- Staff on some acute wards did not receive regular supervision.
- Patients on Lilacs ward and ward one did not have access to a regular programme of meaningful activities as these were often cancelled or not being provided.
- Detained patients on Lavender ward did not always have a consent or authorisation certificate in place.

In the wards for older people with mental health problems we found:

- Working age adults were being admitted to the wards for older people. This compromised the safety of patients. There had been serious incidents on Crocus ward involving younger adult patients.
- The wards for older people did not comply with guidelines for gender separation. Some patients had to walk through communal areas to reach the bathroom, which compromised their privacy and dignity.
- Staff carried out a visual check on patients' skin integrity when they were admitted to the wards. They did not carry out a formal assessment of risk of developing a pressure ulcer for every patient. This was contrary to trust policy.

However, on ward three a harm free care pilot had been conducted. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. All acute adult wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas. Emergency resuscitation equipment was in place and checked regularly. Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. Learning from serious incidents led to improvements in care.

On Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. Some of the acute inpatient wards had recruited peer support workers. They were part of the team and offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward and helped staff and patients to work positively together.

On the older people's wards staff carried out assessments of patients' risk of falls and put plans in place to address the risks identified. Staff managed medicines safely. The ward environments had been adapted to make them more suitable for patients with dementia. There were sufficient staff to care for patients safely. Staff had been encouraged to report all incidents and there had been an increase in the number of patient falls reported by staff as a result. Staff assessed patients' needs and put care plans in place to address the needs identified. Patients had good access to physical health care. Several staff had

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completed specialised training in dementia care. Staff received regular supervision and most had completed an annual appraisal. Multi-disciplinary teams worked well together on the wards

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## The five questions we ask about the services and what we found

We always ask the following five questions of the services.

**Are services safe?**

In the acute wards for adults of working age and psychiatric intensive care units we found that:

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On the older people's inpatient wards staff carried out assessments of patients' risk of falls and put plans in place to address the risks identified. Staff managed medicines safely. The ward environments

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**Are services effective?**

In the acute wards for adults of working age and psychiatric intensive care units we found that:

- On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients needs, and did not reflect their preferences. Patients were not involved with the development of care plans.
- Staff on Lilacs ward in particular lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent and did not understand their legal responsibilities.
- Staff on several wards did not receive regular supervision.
- Patients on Lilacs ward and ward one did not have access to a regular programme of meaningful activities as these were often cancelled or not being provided.
- Detained patients on Lavender ward did not always have a consent or authorisation certificate in place.

In the wards for older people with mental health problems we found that:

- Staff had left patient related information unattended in a ward dining room.
- Patient observation records were not always completed or were completed retrospectively.

However, on Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. Some of the acute inpatient wards had recruited peer support workers. They were part of the team and offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward and helped staff and patients to work positively together.

On the older people's inpatient wards staff assessed patients' needs and put care plans in place to address the needs identified. Patients had good access to physical health care. Several staff had completed specialised training in dementia care. Staff received regular supervision and most had completed an annual appraisal. Multi-disciplinary teams worked well together on the wards.

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## Our inspection team

Team leader: Judith Edwards, Care Quality Commission.

The team that inspected the wards for older people with mental health problems consisted of an inspection manager, and two inspectors.

The team that inspected the acute wards and psychiatric intensive care unit (PICU) consisted of three inspectors, a pharmacy inspector, a senior nurse manager and an expert by experience.

## Why we carried out this inspection

We inspected this service to find out whether improvements had been made in acute wards and psychiatric intensive care unit and in wards for older people with mental health problems since our last inspection in March 2014.

## How we carried out this inspection

To see whether improvements had been made in key areas since the inspection in March 2014 we focussed on two key questions:

- Is it safe?
- Is it effective?

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit the inspection team:

- visited four acute admission wards on three hospital sites;
- visited the psychiatric intensive care unit (PICU) at Springfield University Hospital;
- visited two wards for older people with mental health problems at two hospitals;
- spoke with 25 patients using the services;
- spoke with three carers of patients;
- conducted a period of structured observations on the two wards for older people;
- observed how staff were caring for patients;
- spoke with the managers, acting managers or deputy managers of each ward
- spoke with 45 staff members including nurses, health care assistants, doctors, an occupational therapist, a dietician, a modern matron and pharmacists;
- Attended and observed a ward round and a handover between morning and afternoon shifts;
- looked at 27 clinical records of patients;
- carried out a check of the clinic rooms on all wards;
- carried out a specific check of medicines on Lilacs ward;
- looked at a range of policies, procedures and documents relating to the running of the services.

## Information about the provider

South West London and St George's Mental Health NHS Trust provides community and hospital mental health services to people living in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. They also offer some specialist services to people throughout the United Kingdom.

The acute inpatient services and psychiatric intensive care unit (PICU) were provided at three different hospitals in south west London. Some patients were detained under the Mental Health Act 1983 and the rest were admitted informally.

The older people's wards provided inpatient services to older adults with organic mental health conditions such

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as dementia and other forms of cognitive impairment and also patients with functional mental health problems such as psychosis, depression and anxiety. Some patients were detained under the Mental Health Act 1983 (MHA), some had a Deprivation of Liberty Safeguards (DoLs) authorisation in place and some patients were admitted informally.

During the inspection we visited the following wards:

Lilacs ward, a 20 bed mixed sex acute admissions ward at Tolworth Hospital.

Ward three, a 20 bed mixed sex acute admission ward at Springfield University Hospital .

Jupiter ward, a 23 bed mixed sex acute admission ward at Springfield University Hospital.

Ward one, a 13 bed male psychiatric intensive care unit at Springfield University Hospital.

Lavender ward, a 23 bed mixed sex acute admission ward at Queen Mary's Hospital.

Jasmine ward, a 17 bed ward for older adults at Tolworth Hospital. There were 13 patients admitted to the ward on the day of our inspection.

Crocus ward, a 21 bed ward for older adults at Springfield University Hospital. There were 16 patients admitted on the day of our inspection.

We last inspected the South West London and St George's Mental Health NHS Trust in March 2014. At that time compliance actions were made at three hospitals, Tolworth, Springfield and Queen Mary's.

In the older inpatient wards for older people we had been concerned about inconsistent risk assessment of patients. When risks had been identified staff had not always taken action to manage those risks, this particularly related to falls risk assessments. Incidents were not always being reported and patient's care plans were not detailed or personalised. We also had concerns about gender separation on Azaleas ward (now closed). On the acute wards and PICU we had previously had particular concerns about the way medicines were being managed on Lilacs ward and poor risk management plans on some wards.

These compliance actions (now known as requirement notices) were inspected as part of this focussed inspection. We found improvements had been made and the requirements had been met. However, we identified a number of other concerns or the same concerns on different wards during this inspection. We made four requirement notices where there had been breaches in regulations.

## What people who use the provider's services say

During the inspection the teams spoke with 28 patients and carers. In addition we carried a period of structured observations of interactions between patients and staff on two wards for older people.

Much of the feedback we received was positive. On the acute inpatient wards and PICU all of the patients we spoke with said that they felt safe on the ward. Most patients said that nursing staff were pleasant and kind. The patients on ward three were complimentary about all of the staff. They particularly praised the occupational therapist, activities co-ordinator and acting ward manager.

On the wards for older people with mental health problems one patient reported how calm staff were even when patients were distressed. Patients spoke positively about staff and felt safe on the ward. Staff had time to talk to patients and relatives. A relative told us they were involved in their family member's care and felt their views were taken on board. Patients said they were seen regularly by the doctor and felt listened to. They felt fully involved in decision-making about their care and treatment. One patient told us they had seen other patients falling and said the doctor always attended promptly to help them. Patients thought the wards were clean. A carer told us the ward had a lovely atmosphere. Patients had access to drinks when they wanted one and staff encouraged patients to drink.

We saw staff supporting patients in a sensitive, friendly manner and taking time to talk with relatives. Patients spoke with staff and others openly and in a relaxed

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manner. Staff were very caring and spent time with patients individually. They gave patients time to express themselves and do things for themselves. They provided calm reassurance when patients were distressed.

However, in relation to the acute inpatient wards and PICU patients on Lilacs ward felt there were issues with agency staff. This was around their commitment and not knowing the patients. They also said there were few activities on the ward. Jupiter ward patients felt there were limited activities available to them. They were also unhappy that the TV had been broken for some time and not replaced.

On the wards for older people there were mixed views on the meals provided. One patient said it was horrible whereas others said the food was good and there was always a choice. There were also mixed views on the quality of activities provided. One patient said they were too simplistic while someone else said they were good and met their needs.

## Good practice

- On ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in a way that was easy to understand.
- On Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. It also meant ward rounds were not as long and patients' needs were reviewed daily.
- Some of the wards had recruited peer support workers. They worked on a full or part-time basis. These were people who had experience of, or were using, mental health services. The peer support workers were part of the team. They offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward. They also helped staff and patients to work positively together.

## Areas for improvement

**Action the provider MUST or SHOULD take to improve**

**Action the provider MUST take to improve the acute wards for adults of working age and psychiatric intensive care units:**

- The provider must ensure that all ligature risk assessments are detailed, specific and consistently assessed. Measures to minimise risks must be explicit and made known to all ward staff.
- The provider must ensure that patient risk assessments and management plans are updated following risk incidents. Environmental risks must be considered and risk management plans followed for all patients.
- The provider must ensure that when patients on Lavender ward have 'as required' medicines the reason for administering these medicines is clearly recorded and reviewed regularly.
- The provider must ensure that patients on Lilacs ward are routinely involved with developing their care plans. Care plans must be person centred and reflect patients' needs and preferences. Patients should always be offered copies of their care plans.
- The provider must ensure that staff on Lilacs ward understand how the Mental Capacity Act and Deprivation of Liberty Safeguards are applicable to their work. They must ensure staff have the knowledge to be able to apply the Mental Capacity Act.

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**Action the provider MUST take to improve the wards for older people with mental health problems:**

- The provider must ensure that the older people's wards do not provide beds for working age adults who are not clinically appropriate for a service for older people.
- The provider must ensure that the wards for older people comply with guidelines for gender separation.

**Action the provider SHOULD take to improve the acute wards for adults of working age and psychiatric intensive care units:**

- The provider should ensure that equipment on Lilacs and Lavender wards is maintained on a regular basis, so that it is safe to use and fit for purpose.
- The provider should ensure that all ward staff receive regular supervision.
- The provider should ensure that an appropriate programme of meaningful activities is provided for patients on Lilacs ward and ward one.
- The provider should ensure that each patient on Lavender ward has a consent (T2) or authorisation (T3) certificate where this applies. This certificate should be attached to the medicine administration record for reference when medicines are administered.

**Action the provider SHOULD take to improve the wards for older people with mental health problems:**

- The provider should ensure that a 'Waterlow' assessment is completed for every patient on admission, in line with trust policy.
- The provider should ensure that all confidential patient records are stored securely and not left unattended on the wards.
- The provider should ensure that all staff complete patient observation records contemporaneously and in full.

# South West London and St George's Mental Health NHS Trust

**Detailed findings**

## Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

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In the wards for older people with mental health problems we found that:

- Working age adults were being admitted to the wards for older people. This compromised the safety of patients. There had been serious incidents on Crocus ward involving younger adult patients.
- The wards for older people did not comply with guidelines for gender separation. Some patients had to walk through communal areas to reach the bathroom, which compromised their privacy and dignity.

# Detailed findings

- Staff carried out a visual check on patients' skin integrity when they were admitted to the wards. They did not carry out a formal assessment of risk of developing a pressure ulcer for every patient. This was contrary to trust policy.

However, on ward three a harm free care pilot had been conducted. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. All acute adult wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas. Emergency resuscitation equipment was in place and checked regularly. Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. Learning from serious incidents led to improvements in care.

On the older people's inpatient wards staff carried out assessments of patients' risk of falls and put plans in place to address the risks identified. Staff managed medicines safely. The ward environments had been adapted to make them more suitable for patients with dementia. There were sufficient staff to care for patients safely. Staff had been encouraged to report all incidents and there had been an increase in the number of patient falls reported by staff as a result.

## Our findings

### Safe and clean environment

- The acute ward layouts did not enable all areas to be observed easily. Some wards, such as ward three, had glass 'walls' in parts of the ward. This meant most of the ward could easily be observed. On Lilacs ward, however, there were small corridors in the bedroom areas. No mirrors were in place and staff could not easily observe these areas. A staff member walked around each ward from every fifteen minutes to every hour to observe these areas.
- A ligature risk assessment had been carried out on Crocus ward, a ward for older people, in October 2014. No high risk ligature points had been identified. Where risks had been identified there were plans in place to manage these safely. A ligature risk report for Jasmine ward dated January 2015 identified a number of ligature risks on the ward and the actions being taken to remove them.
- Each acute admission ward and PICU had conducted a ligature risk assessment. However, these varied in the level of detail recorded. On Jupiter ward and ward three, specific details of the risks were recorded, along with specific measures to control and minimise the risks. Each risk was coded to identify the severity of the risk. We found two ligature risks on ward three which had not been identified.
- On Lilacs ward, ligature risks were recorded by room. The risks in each room were not always recorded. Measures to minimise the risks were general and not specific. One ligature risk in all of the bedrooms had been assessed to be a different severity in different rooms. Some work had been undertaken on Lilacs ward to remove ligature risks.
- On ward one the risk assessment did not clearly detail all risks or the control measures for these. A numerical score was used to indicate the severity of risk. This was different from other wards and did not follow the providers' policy. Staff did not understand what the scoring meant. The lack of detail in the risk assessments on Lilacs ward and ward one put patients at risk.
- On acute wards the ligature risk assessments were not readily available to staff. Only the ward manager or deputy manager could access them. This meant ward staff were not always aware of all of the ligature risks.
- In the wards for older people none of the bedrooms had en-suite facilities and patients used shared bathrooms and showers. On Jasmine ward there were separate corridors for female and male bedrooms. Both corridors were accessed by using a code which provided a level of security. Patients were given the code to their specific corridor. However, on another corridor joining the male and female corridors to the communal areas of the ward and the front door there were four additional bedrooms and a bathroom that patients in those rooms could use. There were two female patients using those bedrooms at the time of our visit. In order to reach the bathroom the two female patients needed to use a corridor being used by both men and women to access the other

bedrooms or the day room. This meant the layout of the ward did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity.

- On Crocus ward most patient bedrooms were separated according to gender. The male and female bedroom areas were on opposite sides of the ward and had their own dedicated bathrooms. However, there were two bedrooms on a separate corridor, termed flexi-beds by staff. At the time of our visit there was one female patient using a flexi-bed. This area did not have a dedicated bathroom or toilet. To reach the female bathroom the patient in the flexi-bed needed to walk across the communal day room. This meant the layout of the ward did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity.
- All acute admission wards, except the PICU, provided mixed sex accommodation. These wards adhered to national guidance by having separate male and female areas.
- There were fully equipped clinic rooms on wards. Records showed that the emergency equipment was regularly checked and maintained by staff.
- On Lilacs ward, the sphygmomanometer, used to measure blood pressure, had last been serviced before 2010. This meant blood pressure recordings may not be accurate. On Lavender ward a portable nebuliser was available for patients with asthma. This had last been serviced in 2011. This meant that medicines given by the nebuliser may not be completely effective.
- The PICU (ward one) had a seclusion room. Staff were able to observe all areas of the seclusion room. There was an adjoining shower and toilet. To ensure patient privacy, a roller blind could be used over the observation panel. There was an intercom for communication with staff and a clock was visible.
- Ward areas were mostly clean and well maintained. Patients told us the wards were always clean. A patient led assessment of the care environment (PLACE) had taken place on Jasmine ward the week before our visit. The results were not yet available but the matron told us some improvements were needed. These included removal of dust from under some beds and high areas of the ward. During our visit to the ward we noted the toilet next to the quiet room in the corridor had dust on the walls and appeared to need cleaning. The chart on the wall that recorded when the toilet had last been checked and cleaned showed that it had not been since Monday, two days before our inspection. On ward one, we observed the ward domestic inform a nurse that two toilets were blocked. The nurse immediately reported this to the facilities department to be addressed.
- On Lilacs ward, an acute ward, there were weekly hygiene checks. This included checking washbasins, liquid soap, sharps bins and infection control disposables. There were, however, three packs of high energy protein drinks which were past their use by date. Two packs had expired two months previously, the other pack seven weeks previously. We also noted that the fridge temperature in the patients' kitchen had not been checked for four days in the previous week.
- The ward environments on the older people's wards had been adapted to make them more comfortable for people with dementia or other types of cognitive impairment. Contrasting colours were used to help patients. Colour and contrast can be used to help people with sight loss and dementia to identify key features and rooms. On Jasmine ward there was good signage with photographs that helped patients identify their bedrooms.

### Safe staffing

- There were sufficient staff on the wards to care for patients safely. Ward managers were able to bring in additional staff to cover any shortages or if the needs of patients changed. Safe staffing levels and the number staff on duty on the day were on display in the wards.
- On both wards for older people there were five staff on duty during the day (three qualified nurses and two unqualified) and four (two qualified nurses and two unqualified) at night. The ward was not full and this was sufficient to meet patients' needs. Staffing levels were scrutinised daily by matrons and at the trust daily staffing meeting. The safe staffing level report for the first half of April showed that Jasmine ward had always met agreed levels. There had been a slight shortfall on Crocus ward although we noted that the ward had not been at full capacity and there were several empty beds.
- On the acute wards and PICU 99% of shifts for nurses during the day had been filled over the previous year. At

night, 139% of shifts were filled. All wards required additional staff above normal staffing levels at times. This was often because some patients required continuous support from a member of staff. On Jupiter and Lavender wards there were less nurses working during the day than required. On Jupiter ward an average of 21 shifts per month had one less nurse than required. On Lavender ward this was an average of 19 shifts per month.

- There was regular use of bank and agency staff on Jasmine ward to maintain safe staffing levels. There were three staff vacancies on Crocus ward. Two vacancies were for nurses and the third for a health care support worker. Staff had been recruited to two of these posts and were undergoing pre-employment checks.
- Lilacs ward and ward one had the highest number of staff vacancies. Lilacs ward had eight nurse vacancies. There was also one health care assistant vacancy. Bank and agency staff were used to cover these shifts. Where possible, staff who knew the ward and patients, were used. The matron informed us that six of the nurse posts had been recruited to.
- Ward performance reports of the period from January to March 2015 showed that Jasmine ward had a staff sickness rate of 3% whilst on Crocus ward this was higher at 12-15%. Staff turnover in the last six months had been quite high on both wards. On Jasmine ward it was reported to be 24% and on Crocus ward it was more than 30%.
- Staff reported that the newly introduced trust staff bank was unable to provide staff at short notice, for example, when a staff member was sick. They felt the previous system had been much more responsive.
- There was medical cover for each of the wards throughout the 24 hour period.
- Staff had received, and were mostly up to date with mandatory training. The performance dashboard on display in Jasmine ward showed that 84% of staff were completely up to date with training requirements in April 2015.

### Assessing and managing risk to patients and staff

- There had been 29 episodes of seclusion in the last six months on the acute wards. These had all taken place on ward one, the PICU.
- There had been 83 episodes of restraint. These were highest in Jupiter ward (24) and ward three (23). Lavender ward reported there had been only one restraint in six months. There were six prone restraints recorded. These were highest in ward one (two) and ward three (two). In March 2015 the national reporting requirements for prone restraint changed. All of the prone restraints recorded occurred after this time. The threshold for the classification of prone restraint was lower following the introduction of new guidance.
- Staff had recorded 158 falls on Jasmine and Crocus wards in 2014/2015. The reporting of falls on the older people's wards had increased significantly between the second and third quarters of 2014, from an average of seven falls per month to 22 falls per month. This was in response to a greater emphasis on recording falls. The number of falls reported in quarter four fell to an average of 9.5 falls being reported monthly. This followed initiatives to reduce the number of falls including better falls risk assessment and care planning.
- Trust audits of the completion of falls risk assessments showed an improving picture on Jasmine ward where 100% of patients in quarter three had a falls risk assessment on admission. The number of patients who had a falls care plan in place to address identified risks was 71% in quarter three. On Crocus ward the completion of falls risk assessments between June and December 2014 was 65% and 83% of patients at risk of falls had a falls care plan in place.
- We reviewed the records of ten patients on the two wards for older people and saw that a risk assessment was undertaken on every patient when they were admitted to the ward. These included falls risk assessments. Risk assessments were updated regularly or after an incident had occurred if this was sooner. Where risks were identified plans were put in place to manage the risk and keep patients safe. Risk summaries were completed for all patients whose records we checked.
- Staff carried out a visual examination of the condition of patients' skin when they were admitted. Any marks, redness or bruising were recorded on an individual body map. However, staff did not routinely use a recognised tool, a Waterlow assessment, to formally assess patients' risk of developing a pressure ulcer. Only if a patient's presentation suggested they were at risk of

skin breakdown or developing a pressure ulcer would staff complete the Waterlow assessment form. This was contrary to the trust's physical health care and disability policy which stated that a Waterlow assessment must be completed for every patient on admission.

- Patient records showed that pressure relieving mattresses and cushions were obtained for patients assessed as being at risk of a pressure ulcer. Care plans were in place to ensure staff knew how to manage the risk effectively and prevent skin breakdown. There had been three incidents of pressure ulcers reported on the two wards in 2014/2015. Two of these incidents related to the same patient. Two of the incidents were classified as hospital acquired pressure ulcers.
- On admission to the acute wards the risk patients could present to themselves or others was assessed. The risk assessments we viewed varied across the wards. On Jupiter ward there were detailed risk assessments and management plans to minimise risks to patients. Risk assessment and management plans on wards one and three were also detailed and specific. These included risks from bullying, and interventions to manage risks. Risk assessments and management plans were updated weekly and after risk incidents. Staff on ward three described a wide range of interventions they used to reduce risks.
- However, on Lilacs ward one patient had been restrained and received rapid tranquilisation. Their risk assessment and management plan had not been updated following this incident. Another patient had been involved in two risk incidents. Their risk assessment and management plan had also not been updated. A further patient had exposed themselves in a communal area of the ward. This was not identified in the risk management plan, with no plan to support the patients dignity.
- On Lilacs ward there was a notice in the staff office concerning some bedrooms. This stated that patients at increased risk of harm to themselves should not be allocated those bedrooms. We observed that a patient who harmed themselves prior to admission was in one of the bedrooms identified. The patient had been assessed using the ward clinical risk zoning system. The patient was in the red zone indicating the highest risk. Also in their bedroom was a general hospital bed. This bed was not required for medical reasons. This presented a significant ligature risk. Staff had not assessed the risks before the patient moved into the bedroom. The risks presented by the hospital bed did not appear on the ward ligature risk assessment.
- Some patients on the wards presented with a high risk to themselves or others. Some of these patients were supported continuously by a member of staff. On ward one we found that a staff member was allocated to support the patient for the whole shift. This meant the patient and staff member would be together for over seven hours. This had been the case a number of times during the previous two weeks. This practice had the potential to increase risk. The patient could become irritated and frustrated with one member of staff for so long. The level of concentration of the staff member was also likely to decrease over time.
- Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. This was to ensure they were physically well. An incident report was also made. This allowed the provider to monitor the use of rapid tranquilisation.
- On ward three a harm free care pilot had been conducted. This was now on-going. This looked at medicine errors, violence, self harm and falls. This information was presented in an easy to understand way. In the previous month there had been a risk of violence on most days. There had, however, been very few days when violence occurred. This demonstrated that ward staff were managing this risk well.
- Younger adults were sometimes admitted to both of the older adults' wards when there was no bed available in the acute wards. There had been 32 patients under the age of 60 years admitted to Crocus ward since 31/10/2014. Eight of these patients had been under 26 years of age. Seven patients were admitted directly to the ward rather than to an acute bed first. In the same time period six patients aged less than 60 years had been admitted to Jasmine ward. Two of these patients had been under 25 years of age. One patient was admitted directly rather than to an acute bed first.
- On Crocus ward there had been two serious incidents in the previous three weeks, both involving adults under the age of 45 years. One incident had involved a serious assault by a newly admitted younger patient on an older person admitted to the ward. The incident was under

investigation. In the second incident a younger patient had harmed themselves very seriously. Staff were very concerned about the impact of younger, acute, patients being admitted to the older patients ward and the risks this posed to patients.

- The consultant psychiatrist on Crocus ward told us he did not have clinical responsibility for younger age patients admitted to the ward. Any younger age patients admitted to Crocus ward on a Friday were not clinically reviewed by the responsible home team until the following Monday. The inappropriate admission of younger patients to the inpatient wards for older people posed a clear risk of harm to patients. Care and treatment was not being provided in a safe way to patients.
- Staff knew how to safeguard patients from possible abuse. Staff we spoke with had all received training in safeguarding adults and knew how to recognise a safeguarding issue.
- Medicines were managed safely. Medicines were stored in locked cabinets in the clinic room on all wards. We reviewed medicine administration records on all wards and found that most had been completed accurately. On Lilacs ward improvements had been made in the way medicines were managed since the last inspection in March 2014.
- Patients were prescribed 'as required' medicines, which were to be administered only when needed. On Lavender ward one patient had been prescribed 'as required' medicine to help them sleep. Their medicine administration record showed they had been administered this medicine for five nights consecutively. However, there was no record in their progress notes explaining why the medicine had been given. Another patient had the same medicine, and another medicine, at night. This patient had the medicines for six consecutive nights. One night it was recorded that the patient requested these medicines. There was no record of why the medicines had been administered on the other nights.
- Another patient on Lavender ward was prescribed a medicine for sleep regularly. They had received this medicine for almost one month. During this time there had been five medicine reviews and ward rounds. There was no record that the patient's need for this medicine had been reviewed. There was a risk that patients were being given medicines they did not always need.

### Track record on safety

- In the previous year there had been two serious incidents on ward three. A number of procedures had subsequently been put in place to minimise such incidents. The procedures put in place were understood by all staff. There were two serious incidents on Lilacs ward and one on Lavender ward. There were no serious incidents on ward one or Jupiter ward.
- There had been two serious incidents on Crocus ward in the last two weeks. There had been a recent death of a patient admitted to Jasmine ward which was being investigated.

### Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. There was evidence of increased reporting of falls in response to greater encouragement to complete incident reports appropriately.
- Incidents were discussed at clinical governance meetings.
- There was evidence of learning from incidents. Immediate changes had been made to ward processes following a serious incident on Jasmine ward. Other learning had occurred following a medicines incident. Action was taken to prevent a reoccurrence.

# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Summary of findings

In the acute wards for adults of working age and psychiatric intensive care units we found that:

- On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients needs, and did not reflect their preferences. Many patients were not involved with the development of care plans.
- Staff on Lilacs ward in particular lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent and did not understand their legal responsibilities.
- Staff on some acute wards did not receive regular supervision.
- Patients on Lilacs ward and ward one did not have access to a regular programme of meaningful activities as these were often cancelled or not being provided.
- Detained patients on Lavender ward did not always have a consent or authorisation certificate in place.

In the wards for older people with mental health problems we found that:

- Staff had left patient related information unattended in a ward dining room.
- Patient observation records were not always completed or were completed retrospectively.

However, on Lilacs ward, a morning multi-disciplinary handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. Some of the acute inpatient wards had recruited peer support workers. They were part of the team and offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward and helped staff and patients to work positively together.

On the older people's wards staff assessed patients' needs and put care plans in place to address the needs identified. Patients had good access to physical health care. Several staff had completed specialised training in dementia care. Staff received regular supervision and most had completed an annual appraisal. Multi-disciplinary teams worked well together on the wards.

## Our findings

### Assessment of needs and planning of care

- We reviewed the care records of 27 patients across the wards we visited. The needs of patients were assessed on admission to the wards.
- Patients' physical as well as mental health needs were assessed. The performance dashboard on display in Jasmine ward showed that 91% of patients had a physical health assessment on admission. The trust target was 95%.
- Daily checks were made of patients' blood pressure, temperature and pulse. This helped identify any deterioration in a patient's physical health and indicated when staff should escalate concerns to a doctor. The consultant on Crocus ward had delivered practice development sessions to staff on how to complete the national early warning signs (NEWS) chart used to record patients' vital signs. NEWS helped identify when a patient's condition might be deteriorating and a doctor needed to be informed. We saw patient NEWS charts were completed regularly.
- Patient care plans varied across wards. Most patients had detailed care plans in place. These were specific and measurable and identified patients' current needs. Some care plans specifically addressed physical health needs such as the management of diabetes. However,

patient involvement with their care plans was not consistent. In some cases we found significant involvement from the patient. In others there was minimal or no involvement.

- Five patients on Lilacs ward told us that they did not know about their care plan. They also said they had not received a copy. One patient told us that their care plan was basic and did not address their needs. We saw one patient's care plan had two elements. One was with regard to receiving information on their rights under the Mental Health Act. The other stated the need to work towards two recovery goals. There was, however, no information about what these goals were. There was no care plan addressing why the patient had been admitted to hospital. Another patient had one care plan relating to anxiety. This care plan did not address all of the patients' needs. Care plans were not always person-centred and did not reflect patients' preferences.
- Staff recorded daily information about patient care and treatment in their progress notes. These notes varied across wards and within the wards. There were good examples of thorough, detailed progress notes. There were also progress notes which were very brief and described the patients' activities only. There was little record of engagement with, or understanding of, the patient. Some statements in progress notes were general such as, 'no management problem' or 'settled in mood'.
- There were no psychologists in any of the ward multi-disciplinary teams. On ward one there was no occupational therapist or activity co-ordinator. Staff told us that activities on the ward were nurse led. This, however, depended on nursing staff being available. Patients on some wards spoke of activities 'being promised, but never happening'.
- On ward three there was an occupational therapist and activities co-ordinator. There was a full programme of activities. We observed some of these during the inspection. On Jupiter ward the occupational therapist provided six activities per week. There was no activity co-ordinator on the ward.
- Lilacs ward had an occupational therapist. The activity co-ordinator, however, had been absent for approximately three months. There was no temporary replacement. Four activities on the activity programme did not take place at all. A further ten activities did not take place every week. Some took place every two or three weeks. During the afternoon of our inspection, two groups were planned to take place. Neither of them took place.
- Most information needed to deliver care effectively was recorded appropriately and stored securely. However, we found a trolley containing patients' physical health care records left open and unattended in the dining room on Jasmine ward. In addition we found records of observations of patients were not being completed contemporaneously. We observed staff completing observation sheets at the end of the morning shift. There were several gaps in recording. For example, for one patient on level two observations, within eyesight, there was a period of four hours when records had not been completed. For another patient on level two observations there was no observation recording sheet available or being used.

### Best practice in treatment and care

- Policies and procedures gave reference to the national guidance they were based on. This ensured assessments and interventions were evidence based. Staff followed National Institute for Health and Care Excellence (NICE) guidelines on supporting people with dementia and their carers. The trust's falls prevention and bone health policy had been updated and brought in line with NICE guidelines and NPSA rapid response guidance. Doctors considered National Institute for Health and Care Excellence guidance when prescribing medicines.
- Patients had access to good physical health care. Patients on the wards for older people were referred to a range of different health professionals including a podiatrist, speech and language therapist, physiotherapist, and dietician when this was appropriate to their needs.
- Patients' nutrition and hydration needs were assessed and addressed. Patients had access to drinks throughout the day and staff offered and encouraged patients to drink. The service operated protected meal times which meant patients should not be disturbed while they were eating. Where there were concerns about a patient's eating and drinking they were referred to a dietician.

# Are services effective?

- On the acute wards there was no evidence in care records that patients had received a psychology assessment or treatment. None of the patients we spoke with said they received this. Staff told us that if the multi-disciplinary team decided this was required a referral would be made.
- Staff undertook regular clinical audits. These included audits of the completion and the quality of documentation.
- A real time electronic feedback machine was situated in the wards. This allowed patients and carers to provide feedback about the service. The service responded to feedback from patients and carers and made improvements. For example, patients on Jasmine ward had asked for medicines to be given earlier. In response morning medicines were reviewed by the medical team and prescriptions were spread across the day.

### Skilled staff to deliver care

- Each ward had a multidisciplinary team (MDT). On most wards the team included nurses, doctors, healthcare assistants, occupational therapists and activities co-ordinators. Pharmacists carried out regular reviews of the prescribing of medicines. All staff, patients and carers we spoke with on Jasmine ward praised the work and enthusiasm of the activity co-ordinator.
- On the wards for older people staff received individual supervision every month. Staff told us supervision usually took place as planned.
- Nursing staff on Jupiter and Lavender wards had monthly supervision. They also had reflective practice groups. On ward three staff also had supervision monthly. However, in the previous four months between 10 and 18 staff supervision sessions per month had not taken place. This was largely due to a lack of time because of reduced overlap times between the shifts during the day. This meant there were not enough staff to manage the ward safely as well as support supervision sessions. Reflective practice groups took place every two weeks. Staff on ward one and Lilacs ward did not receive regular supervision. There were reflective practice groups.
- On average 89% of nursing staff on the acute wards had an appraisal in the previous year. The quality and performance tracker for April 2015 for Crocus ward, a ward for older people, showed that 85% of staff had received an annual appraisal. Records showed that on Jasmine ward 86% of staff had received an annual appraisal.
- All staff on the older people's wards were due to undertake a three day training course in dementia. The course was being provided by a local university. Eight staff from Crocus ward and five staff from Jasmine had completed the training since December 2014. Staff had received bespoke training in how to restrain an older person safely. Additional training in physical health concerns was planned and was also being delivered by a local university. Some staff had already completed this. The three day course was provided twice a year and was being gradually rolled out to all staff. The training helped to ensure that staff had the skills to care for older people effectively. On the acute wards staff had completed additional training in family work for psychosis, cognitive behavioural therapy and psychosocial interventions.
- All new staff received an induction which included the model of care and how to support the needs of their patient group. Staff also had a period of shadowing other staff before taking on their full responsibilities
- We carried out periods of structured observation on both wards for older people. We saw that staff were skilled in the way they delivered care to patients. They were kind and compassionate and responded in a very caring way to patients who were distressed. They spoke with patients at eye level. They did not restrict patients' movement around the wards unnecessarily but ensured patients remained safe. They took time to engage with patients on an individual basis.
- Staff were offered support after serious incidents occurred.

### Multi-disciplinary and inter-agency team work

- The multi-disciplinary teams worked well together. On Lilacs ward, a morning multi-disciplinary team (MDT) handover took place every weekday. This enabled continuous medical review of patients without waiting for the next ward round. It also meant ward rounds were not as long and patient care was reviewed daily. We observed part of a MDT meeting on ward one. The MDT discussed the risks affecting of a patient thoroughly as a team and discussed plans for interventions to minimise the risks.

# Are services effective?

- Staff on all wards described good relationships with community teams and social workers. On Lavender ward the home treatment/crisis team was based on the ward. Staff said this helped working relationships. It also enabled positive joint working on the admission and discharge of patients.
- On the wards for older people the dietician monitored the weights of referred patients, organised meal replacements, reviewed the menus and advised on allergies. The physiotherapist undertook falls risk assessments and ensured appropriate walking aids and foot wear were available to reduce the risk of falls.
- Some of the wards had recruited peer support workers. They worked on a full or part time basis. These were people who had experience of/ or were using mental health services. The peer support workers were part of the team and offered insight into what it was like to be a patient. They helped patients orientate themselves to the ward and helped staff and patients to work positively together.

### Adherence to the MHA and the MHA Code of Practice

- On the acute wards records showed that patients detained under the Mental Health Act 1983 (MHA) were informed of their rights on a regular basis.
- We reviewed records of patients recently placed in seclusion on ward one. Nursing, medical and multidisciplinary reviews took place at regular intervals. This was in accordance with the Mental Health Act 1983 Code of Practice.
- On Lavender ward two patients had been treated under the MHA for more than three months. There was no consent (T2) or authorisation (T3) certificate attached to either patient's medicine administration records. Certificates for both patients could not be found. This meant that medicines were being administered without assurance that consent or authorisation had been provided.

### Good practice in applying the MCA

- The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were poorly understood by many staff on the acute wards. There was little understanding of the five principles, best interests and lasting power of attorney. This meant that the MCA or DoLS could be applied without the appropriate safeguards for patients. It also meant that situations when the MCA may be applicable may not be recognised. Staff often confused the term 'capacity' with the Mental Health Act definition.
- Lilacs ward staff did not consider that the MCA or DoLS was applicable to their patient group. It was noted that half the patients on the ward were informal patients. Three weeks prior to the inspection an informal patient was admitted to the ward. Upon admission, and for four days, the patient repeatedly said they should not be in hospital. On one occasion the patient said they wanted to leave. There was no record that the patient had been assessed under the MCA or the MHA. This meant the patient could have deprived of their liberty without authorisation. The patient was detained under Section 5 of the MHA on day four of the admission.
- However, on the wards for older people staff were trained in and had good understanding of MCA and DoLS. Several patients had DoLS authorisations in place. Where emergency authorisations had been granted the service had applied for and received a regular authorisation. A trust audit of consent and capacity practice carried out from January – March 2015 reported that most records on Jasmine ward demonstrated good practice.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>The care and treatment of service users was not always appropriate or did not meet their needs and reflect their preferences.<br>On Lilacs ward not all patients were aware of their care plans. Care plans did not address all of the patients' needs and did not reflect their preferences. Many patients were not involved with the development of care plans.<br>This was a breach of regulation 9 (1)(a)(b)(c)(3)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>Patients were not always treated with dignity and respect. The layout of both wards for older people meant that the wards did not comply with guidance on same sex accommodation and compromised patients' privacy and dignity.<br>This was in breach of regulation 10(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>Staff on Lilacs ward lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a risk that they did not recognise when a patient was unable to give consent to care and/or treatment and did not understand their legal responsibilities. |

This section is primarily information for the provider

# Requirement notices

This is a breach of regulation 11

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Care and treatment was not always being provided in a safe way:<br><br>On Lilacs ward, patient risk assessments and management plans were not always updated following risk incidents. Staff had not always followed risk management plans.<br><br>Ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely.<br><br>On Lavender ward some patients were administered 'as required' medicines every night. The reasons why patients required these medicines was not always recorded.<br><br>Acute adult patients received care and treatment on the older people's wards when this was not always clinically appropriate. This posed a clear risk of harm to older patients.<br><br>This was a breach of regulation 12 (1)(2)(a)(b)(g) |