St George's University Hospitals NHS Foundation Trust

RJ7

Community health inpatient services

Quality Report

Queen Mary's Hospital
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Date of inspection visit: Announced visit, 21-23 June 2016. Unannounced visit, 6 July 2016.
Date of publication: 01/11/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ7X3	Queen Mary's Hospital	Mary Seacole Ward Gwynne Holford Ward	SW15 5PN

This report describes our judgement of the quality of care provided within this core service by St George's University Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by St George's University Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of St George's University Hospitals NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Summary of findings

Overall summary

We rated this service as inadequate because:

- Changes had been made to Gwynne Holford Ward since our last inspection without due regard for the impact on people's safety. The premises were not appropriate for the service provided and the layout had contributed to fragmented care. The care was not delivered in a way that focused on people's holistic needs.
- There were critical shortages of staff on Gwynne Holford Ward and not all of the staff on the ward had the right skills and knowledge to do their job. Staff told us that patients were being admitted with more complex needs and they found this challenging.
- Bedrails were used for many patients, without it being discussed and there being any clear indication for their use. There had been no consideration by staff that the use of bedrails was a form of restraint and was possibly depriving patients of their liberty.
- There was a lack of urgency by nursing staff to get the deteriorating patient medically assessed.
- Although we saw some good areas of practice, there was variable implementation of evidence-based care. Processes in documentation, administration of medicines, infection control and prevention and responding to the deteriorating patient were weak areas on Gwynne Holford Ward.
- Incidents were not consistently reported or acted upon on Gwynne Holford Ward and opportunities to learn from these and improve care were missed.

However:

- Staff felt valued by their peers, matrons and ward managers. Staff had a strong focus on providing compassionate care.
- There was excellent multidisciplinary team working and there were clear referral processes. Both wards aimed in their rehabilitation programmes to maximise the functional and physical ability of the patient.

Summary of findings

Background to the service

Adult community inpatient services are provided in two inpatient wards at Queen Mary's Hospital, Roehampton. Mary Seacole Ward has 42 beds and provides sub-acute care, treatment and rehabilitation for older people. Gwynne Holford Ward has 46 beds and provides rehabilitation and support for adults who have had limb amputations or who require neurorehabilitation.

Mary Seacole Ward is in the trust's community services division, whilst Gwynne Holford Ward is in the trust's surgery, theatres, neurosciences and cancer division.

Our judgements were made across the two community inpatient wards. Where differences occurred we have highlighted them in the report.

Our inspection team

Chair: Dr Martin Cooper

Team Leader: Nick Mulholland, CQC

The team included CQC inspectors and a variety of specialists including, a rehabilitation nurse, a GP, a physiotherapist, a pharmacist and one person with experience of using services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 21-23 June 2016 and an unannounced visit on 6 July 2016.

During our inspection, we reviewed information from a wide range of sources to get a balanced view of the hospital. We reviewed data supplied by the trust and visited both wards in the hospital. We spoke with 18 patients and five relatives. We also observed care being delivered by staff.

We visited the two community inpatients wards at Queen Mary's Hospital and looked at the quality of the environment and observed how staff were caring for patients. We looked at a range of policies, procedures and other documents relating to the running of the service.

We held a number of focus groups and drop-in sessions where staff from across the trust could talk to inspectors and share their experiences of working at the trust. Staff from Queen's Mary's Hospital did attend the focus groups, although attendance was poor, due to the groups being held at St George's, Tooting. We spoke with over 34 members of staff working in a wide variety of roles at the hospital.

Summary of findings

We reviewed a variety of documents including 70 sets of care records, audits, minutes from meetings, clinical governance and performance monitoring data. We received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection and looked at patient feedback about the service over the past year.

What people who use the provider say

- We spoke with 18 patients and seven relatives across the two wards Gwynne Holford and Mary Seacole wards. During our inspection, we heard positive comments from patients and relatives.
- Patients described the staff as 'very kind, caring' and tremendous'. Patients told us they received rehabilitation activities and sessions, many were pleased with the progress they had made.
- A few patients told us that staff were very busy, especially at night and this meant they did not always get care in a timely way.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- **Action the provider MUST take to improve**
- Ensure the deteriorating patient is medically assessed in a timely manner.
- Urgently review nursing staffing levels and recruit to establishment of substantive staff.
- Ensure access for agency staff to trust computer systems including the trust electronic incident reporting system.
- Ensure consistency of incident reporting and investigation, staff feedback, learning and improvements from incidents.
  - Review medicines administration and recording on Gwynne Holford and Mary Seacole Wards to take account of Gwynne Holford patients moving between two floors.
- Review and improve patient record keeping, to take account of patients moving between two floors.
- Review and improve infection control and hand hygiene compliance and training.
- Ensure adequate life support training and training in recognition of a deteriorating patient.
- Ensure mandatory training levels achieve the trust mandatory training target.
- Review the policy for provision of bedrails to ensure non-breach of DoLs requirements.
- Ensure care is provided in line with current best practice guidelines.
- Ensure effective pain evaluation and pain management.
- Review individual staff competency requirements for nursing and medical staff and ensure correct skills competence.
- Review and improve staff supervision, training and staff development.
- Provide trust intranet access to agency staff for policies and trust information.
- Ensure that the trust complaints and compliments procedure is publicised and readily available to all patients.
- Ensure that action is taken to reduce significant issues that threatened the delivery of safe, effective care in particular on Gwynne Holford Ward.
- Review the impact of service changes on the quality of care following the increase of the number of patient beds on Gwynne Holford Ward..
- Ensure effective senior leadership on Gwynne Holford Ward.
- Take steps to effectively reduce observed high levels of staff stress and work overload on Gwynne Holford Ward.

St George's University Hospitals NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as inadequate because:

- There was a lack of urgency by nursing staff to get the deteriorating patient medically assessed.
- There were substantial staff shortages Gwynne Holford Ward, this increased the risk of harm to people who used the services.
- Incidents were not consistently reported or acted upon on one ward and opportunities to learn from these and improve care were missed.
- Medicines were not always prescribed and administered safely and in line with the trust's policy and national guidance.
- Changes had been made to one of the services since our last inspection without due regard for the impact on people's safety.
- There was no consistent approach to infection prevention and control on one of the wards, along with poor compliance with hand hygiene and infection control training.
- There were low rates of basic life support training and variable knowledge amongst staff on how to respond to a deteriorating patient and on what action to take in a medical emergency.

However:

- Staff on both wards worked together to monitor their safety performance and protect patients from harm.
- Staff were knowledgeable about their role in safeguarding people.

Safety performance

- There had been no incidents of 'Never Events' which are incidents determined by the Department of Health (DH) as a serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Inadequate

Are services safe?

- Adult community inpatients reported a total of two serious incidents between May 2015 and April 2016, one being a hospital acquired grade three pressure ulcer and one being a fall. There were 387 incidents reported, 45% were categorised as falls, the majority were classed as no harm. Nine percent of incidents were pressure ulcers grade one or two and 6% were medication incidents.
- The trust collected safety thermometer data in relation to care provided to patients. The NHS Safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including pressure ulcers, catheter-related urinary tract infections and falls. Safety thermometer information was displayed on the walls so that staff and visitors were aware of performance on the ward. It was not possible to compare this information with national data due to the small numbers involved. Senior nurses from the two wards met daily to review and record safety performance.
- Safety performance information was consistent and monitored. Information on incidents was not robust as there was a potential for under reporting on Gwynne Holford Ward with half of the staff not being able to report on the electronic reporting system. Some information for example on staffing incidents did not correspond on different systems used to collect data. This meant that information on incidents was not reflecting the incidents that were occurring and that opportunities for learning were missed.
- There had been no cases of venous thromboembolism (VTE) recorded over the last twelve months. Mary Seacole Ward was recognised as one of the best performing wards over 2015/16 for the trust's VTE prevention programme. New pressure ulcers fluctuated over the 12 month period from a high of five in July 2015 for the two wards to one in February 2016. Any patients with skin lesions or concerns about their skin integrity were discussed at the nursing handover.
- The number of recorded falls with low harm also fluctuated over the year with a peak of three falls in March 2016. Falls were recorded and the number displayed for both wards each month. On Gwynne Holford Ward falls prevention information was displayed on a board and there had been an analysis of falls by the therapy staff. On both wards we saw falls risk assessment tools were used to determine the risk of falling, with action and evaluation taken to prevent falls or further falls.
- The incidence of catheter related urine infections and new urinary tract infections (UTIs) over the year varied from one in October 2015 and in March 2016 on Gwynne Holford Ward to five separate incidences in October, December, February, March and April on Mary Seacole Ward.
- Safety performance on falls, pressure ulcers and UTIs were collected and discussed daily within the senior nurse reviews, held jointly between the two wards.
- On Gwynne Holford Ward, an audit of falls by the therapists had identified six contributing risk factors and action plans on how to manage and support these. However, there was inconsistent screening for patients at risk of falls. The action plans followed NICE guidance on the prevention and management of falls. Some patients who were at an increased risk of falling had not been assessed and intervention and support to minimise this had been missed.
- On Mary Seacole Ward, patient's needs were assessed and care and treatment was delivered in line with NICE quality standards relating to the assessment and prevention of falls and pressure ulcers. We also saw patients attending a half hour workshop on preventing falls.

Incident reporting, learning and improvement

- There were significant numbers of agency staff without access to the trust electronic incident reporting system. Recording of incidents when there were inadequate levels of staff with the right skills or system access did not consistently correspond with nursing scorecards provided by the trust, the safe staffing alert system and the incident reporting system.
- Incidents were recorded and reported using the trust electronic recording system. Staff told us they understood the importance of reporting incidences. The process for reporting incidents was printed off and available for staff in the wards' Communication, Action, Resources, Education (CARE) folder.
- The process for reporting incidents was not consistent. Agency staff on both wards and health care assistants on Gwynne Holford Ward did not have access to the reporting system. On Gwynne Holford ward agency

nurses made up 57% of the nursing staff. The head of nursing for Gwynne Holford Ward told us they were very focused on reporting incidents and that staff on the ward were not seeing risks or not reporting incidents.

- The low number of staff having the ability to record incidents meant there was a risk that not all incidents, risks or near misses were identified or reported. Some staff were unsure as to what constituted a near miss.
- On both wards learning from serious incidences and changes in procedures were shared in weekly team meetings and in three monthly multidisciplinary governance meetings. Information on learning from incidences was also available for staff in the wards' CARE folders. All nursing staff on Gwynne Holford told us, because of clinical commitments, it was difficult to be released from the ward to access structured learning from incidents. Three health care assistants on Gwynne Holford ward were not aware of the most common incidents on the ward.
- An undated action plan for Gwynne Holford Ward provided to us after our announced inspection indicated a need to introduce team meetings and other ways to share learning. The action plan reported that staff perceived lack of communication and opportunity to discuss issues, challenges, and to learn and embed this in care. Team meetings had been introduced on Gwynne Holford Ward three months previously.
- A root cause analysis undertaken for the grade three hospital acquired pressure ulcer, had looked at the cause of the pressure ulcer and an action plan had been put in place to prevent a recurrence. The action plan included an increase in training, ensuring pressure relieving equipment was provided promptly and information was shared through the ward governance meeting. On week days a senior nurses meeting held for the two wards monitored the provision of pressure relieving equipment for those who needed it.
- Safety alerts were circulated to teams by senior nurses. Safety alerts were issued when there was a specific safety issue that without immediate action being taken could result in a serious or fatal injury.

Duty of candour

- Staff we asked were aware of the trust's duty of candour policy and practice. We saw in the wards' CARE folder a document dated 2016 setting out specific requirements that the trust must follow. These included informing people when things go wrong with their care and treatment, information about the incident and an apology when things go wrong. On Gwynne Holford Ward the patient information board had information about the duty of candour but not on Mary Seacole. Following the announced inspection the trust was required to increase the awareness of the duty of candour and was to provide patient leaflets, these were not available on either ward. Staff felt the trust was open and honest when something went wrong with patient's care and treatment.

Safeguarding

- Data showed that 50% of staff on Gwynne Holford Ward and 62% on Mary Seacole ward had completed their required safeguarding training against the trust target of 95%. The safeguarding adults policy was being reviewed during our inspection., It was due for review in May 2016. The policy was on the trust intranet, however during our inspection we were unable to access electronic links to guidelines on recognising and the action to be taken on key areas such as domestic abuse, neglect, sexual, physical and psychological abuse. This meant that the trust could not be assured that staff knew how to safeguard patients by accessing the relevant information.
- Nursing staff raised any concerns about the quality of care with senior staff. However these staff were not aware of who else they should raise concerns with if they felt unable to raise them directly with their line manager.
- Staff on the wards including non-clinical staff were aware of what constituted abuse and the actions they would take to protect the safety of patients from abuse. Staff would report to the senior sister or matron. Flowcharts with information on what action to be taken if staff had safeguarding concerns were displayed in the staff room. During a handover senior nurses spoke of contacting the adult safeguarding lead and the advice they had been given about a safeguarding concern they had raised.

Medicines

- On Gwynne Holford Ward during our announced inspection we were concerned that staff were administering medicines across two floors, the ward on the lower ground floor and the neurorehabilitation day unit on the upper floor. Medication administration charts were kept on the day unit above the patient's

individual medication pod locker. During the day patients moved between the two levels, being able to sleep or rest on Gwynne Holford Ward and to have sessions of integrated rehabilitation in the day unit on the ground floor. We observed a member of staff who, having dispensed medicines into pots in the day unit, needed to retrieve a patient's eye drops from Gwynne Holford Ward. The member of staff had to take all medicines downstairs then go back upstairs. The nurse was attempting to mitigate the risk of error by keeping the medicines with her but this increased the risk of error due to distraction and human error. This system did not support the safe administration of medication. On our unannounced inspection we observed that medications were only being administered on the lower ground floor.

- The action plan for Gwynne Holford Ward provided by the trust following our announced inspection identified that nurses could spend up to 75% of their time administering medication and that this impacted on the care that the registered nurses could provide. The plan stated a temporary allocated dedicated whole time equivalent (WTE) pharmacist would administer medications to remove the need for nurses to undertake the medication rounds currently in place. During our unannounced inspection at the time it was planned to implement, nurses were administering medications. Senior nurses told us they were meeting with pharmacists to plan how pharmacists could support and possibly administer medication. After the unannounced inspection we were informed that the ward planned to pilot a pharmacist working alongside the nurses to administer medication and counsel patients on new types of anticoagulants. A similar role was in place on another ward within the trust and competencies developed for this were being considered.
- On both wards nurses did not wear red aprons which identified them as administering medication to avoid being interrupted or distracted. During our announced inspection when administering medication for Gwynne Holford Ward's patients on two floors there were no walls around the medication pods. Staff were visible within the dining area, and they were unable to undertake calculations privately. This meant there was a risk of staff making medication errors due to interruption and distraction. At the unannounced inspection we observed that the patients' medicine pod lockers which contained their medications had been moved downstairs to be at their bedside and were administered on the ward. Nurses told us that medicines were now administered by the nurse responsible for the patient in their allocated bay.
- We looked at 30 medicine administration records (MAR) charts during our announced and unannounced inspections, - 23 on Gwynne Holford Ward and seven on Mary Seacole. Medication errors on both wards were reported on the electronic reporting system with 27 on Gwynne Holford Ward and 17 on Mary Seacole. The MARs we looked at did not have the times recorded of when medication had been administered and half of the MARs had crossings off of medication and these were not signed.
- On Gwynne Holford Ward when we asked senior staff about missing information we observed on the MARs these had not been reported as incidents. Eight recorded incidents and one reported complaint were in relation to late or missed medication, of these six were for patients where the timeliness of administration was important for example patients with diabetes or Parkinson's. Two nurses told us that it was not practice to record when time critical medicines were given or a delay. During the unannounced inspection we heard day staff telling night staff to administer the 6am to 8am medicines, however they were unable to give us a rationale for this. At the time of the announced inspection medications due at this time were administered by the day staff.
- The friends and family test score for Gwynne Holford Ward for May 2016 was 33% for patients being able to talk about medications with staff. It is important to note that due to the nature of the care provided, the number of discharges from the ward on a monthly basis was relatively low, and so a low response rate from the FFT was noted; this is not uncommon in these types of services and so any score should be considered with caution. Patient comments from the ward's suggestion box had reported delays in receiving medication.
- During our unannounced inspection, staff on Gwynne Holford Ward reported that a verbal order for medication had been made for one patient as there had not been a doctor on site. Two nurses had heard the verbal order and were doing this as an extreme circumstance and a once only medication., This adhered to the trust medicines management policy. However the medication, in this case for moderate pain,

had not been recorded and also there was no signature by the prescribing doctor as was set out in the trust's medicine management policy. The senior nurse was not clear on the process and who was accountable for retrospectively prescribing the medication. Nursing and Midwifery Council guidance states that a verbal order is not acceptable on its own that it needs a fax or email prescription or direction to administer stapled to the MAR. There was no supporting fax or emails regarding the verbal orders found in the patient's notes. It had not been recorded as an incident. This meant the trust could not be assured that all medicines were prescribed and administered safely and in line with their policy and national guidance.

- Following the unannounced inspection the prescription for the medication that was given following a verbal order had been prescribed and an incident report had been completed by the senior nurse. The incident was to be investigated by the trust's chief pharmacist.
- Staff could access an on-site pharmacist Monday to Friday 8am to 4pm. At other times they liaised with the pharmacy at St George's hospital. Staff told us there was no delay in receiving medication to take out (TTOs) on discharge or weekend leave.
- Patients on the two wards had paper medication administration records. Electronic prescribing was being rolled out across the trust. We observed staff carrying out appropriate checks to confirm the identity of patients, and ensuring patients took the medication as prescribed. If a member of staff had to leave the trolley or medication pod lockers, we observed they locked them beforehand.
- During our inspections medicines were stored securely either in individual medication pod lockers or in a medicines trolley locked to the wall. Intravenous fluids were stored securely. Controlled drugs (CDs) were stored securely in locked cupboards within a locked cupboard. CDs administered were counter signed by two nurses. Temperature checks had been carried out on drug fridges and recorded daily. During the unannounced inspection on Gwynne Holford Ward we observed the CD cupboard and the drug fridges had been moved onto the ward from the day unit.
- There were arrangements for patients to self-administer their medicines where appropriate with different levels and the nurse checking adherence. These patients had individual pod lockers, with individual keys and a master key held by nursing staff for the pod lockers.

Environment and equipment

- Since the last inspection in 2014 Gwynne Holford Ward had increased the number of beds from 18 to 46 beds. During our announced inspection patients moved between the ward on the lower ground floor and the ground floor where the neuro rehabilitation day unit was and where their rehabilitation treatment took place
- There were four lifts that patients and members of the public could use. The lift was down a long corridor from the ward and outside the lift on the ground floor a yellow line indicated how to get to the day unit. It took us three minutes to walk this route. The amount of time it took nursing and therapy staff to move patients between these two areas had been identified as an issue in the trust action plan provided following our announced inspection. It stated that it impacted on the amount of time available to provide care and safety of patients and that there were not always enough staff to cover both floors safely.
- The trust action plan stated that an agreement had been reached where 2.62 WTE dedicated porters were to be employed in August 2016 to assist with the transfer of patients between floors in the morning and the afternoon with peak times being 7am and 2pm. During our unannounced inspection, we were told that patients were now staying on the ward on the lower ground floor and were only going to the day unit for planned therapy sessions.
- During our announced inspection on Gwynne Holford Ward paper records were stored in different places with staff moving between floors for medication, care planning and evaluation. The geographical distance between the two areas meant that staff could not be assured where patients were. Staff told us that those patients at risk of leaving the ward were observed on an hourly basis but that they could 'easily slip away'. Over the previous twelve months there were nine recorded incidents of patients from Gwynne Holford Ward with high levels of psychological and neurological needs absconding. Of these patients five were found away from the hospital site. During our unannounced inspection we saw the paper records had been moved, patient information and charts were kept together and were now easily accessible for staff.
- As the purpose of Gwynne Holford and Mary Seacole wards was to provide a rehabilitation service to meet individual needs, there was access to a variety of

equipment such as wheelchairs, hoists, standing and walking aids. Staff told us they were able to access pressure relieving equipment promptly. A random check of equipment during our announced inspection on both wards showed that all the moving and handling equipment on Gwynne Holford and Mary Seacole wards were due a service just before our inspection. This inspection had not been carried out. We highlighted this to the senior staff, at our unannounced inspection all the moving and handling equipment had been serviced.

- On both wards machines to record patients' observations were safety checked. The emergency equipment and medication, including resuscitation equipment had been checked every day. However at our announced inspection a blood glucose machine on Gwynne Holford Ward had not been checked on 13 days over a two month period prior to our inspection. We highlighted the missing checks to the senior staff on duty at the time of our inspection for action to be taken. At the unannounced inspection it had not been checked for 10 out of 17 days. This was brought to the attention of the nurse in charge.
- On Gwynne Holford Ward following the change where patients only went to the day unit for therapy sessions, patients now ate breakfast at their bedside table, with lunch and the evening meal at the public restaurant on the ground floor. Previously patients had eaten in the dining area in the day unit.
- During, our unannounced inspection there were ten patients in the day room on the ward watching television and it was difficult to manoeuvre. Three patients told us there was not enough space on the ward with the new arrangements.
- Mary Seacole Ward was a 42 bed ward, run with two teams of nursing staff, one for Mary Seacole A with 20 beds and one for Mary Seacole B with 22 beds. Each had a day/dining room. On Mary Seacole we observed a table in each bay and in the day room with dining chairs where patients could eat their meals or take part in other activities. At the edge of each bay there was a table where staff could observe patients and record patient information
- The premises were in a good state of repair and decoration and were accessible to patients who used wheelchairs. In the Patient-Led Assessments of the Care Environment PLACE survey 2015 for Queen Mary's hospital the average score for the condition, appearance and maintenance was 99% compared with the national average of 90%. Building maintenance was provided by the consortium who owned the building. Staff knew who to contact and told us that maintenance requests where responded to promptly.

Quality of records

- On Mary Seacole Ward, in the patient's folder at the end of their bed was a patient monitoring early warning score (EWS) chart, an intentional rounding chart which set out what staff needed to regularly check to ensure patients were comfortable, a care plan with goals and reviews, information on how to support the patient's mobility and the MAR chart. The past medical notes and the Queen Mary hospital notes were kept securely in a notes trolley. The notes were legible and included assessments by physiotherapists, occupational therapists and speech and language therapists, however signatures were not underlined with the person's printed name. Discharge information was kept with the discharge co-ordinator for four days a week and one day a week with the senior nurse.
- At the time of our announced inspection on Gwynne Holford Ward the storage and recording of patient information was fragmented. The nursing notes were kept in a trolley in a key code access room in the day unit, the trolley was brought down at night to the ward. Staff told us that if they needed medication for a patient on the ward they had to go upstairs to the day unit on a 'five minute journey' to access the MAR. If a nurse noted a change in the patient's condition they would need to make a note in a notebook and then go upstairs later to write it in the nursing notes.
- On Gwynne Holford Ward, we saw fluid and food charts kept separately from patients assessments. Nursing notes on Gwynne Holford Ward did not contain robust reviews or evaluation of nursing interventions, signatures were not underlined with the person's printed name, times of entry were frequently missing.
- On Gwynne Holford Ward, the medical notes were stored in a different cupboard, physiotherapists recorded their care plans and therapy notes in the medical notes.

  The nurses reported spending time having to go from one floor to the other to record in patient's notes. This fragmentation meant staff were not able to review their patients or provide holistic assessment or care

efficiently. Changes in the patients wellbeing, whether t nutrition, skin, general health or hydration was not identified or reported early, thus increasing the patient's risk of undetected deterioration.

- Audits of patient records were requested prior to our inspection and were provided. One senior nurse told us at the announced inspection that an audit of patient documentation was due within the next few weeks. The quality of people's care records were not being assessed so the trust could not be assured that records were written and managed in a way that kept people safe.
- Mary Seacole and Gwynne Holford wards used paper records for patient's notes and charts. We reviewed 30 medicine administration records (MAR), 28 early warning score charts (EWS) used to record observations of patient's vital signs and to prompt staff to take action and 12 sets of medical and nursing records. Staff told us that the roll out of electronic records across the trust was provisionally set for January 2017.
- During our unannounced inspection on Gwynne Holford Ward we observed that all the patient's charts completed by nurses were kept at the end of the patient's beds.

Cleanliness, infection control and hygiene

- There was one patient with MRSA on the ward at the time of our inspection. There were discrepancies in how staff thought they should care for the patient and the restrictions to be in place. There was no documented specialist infection control advice on the individual needs of this patient or a risk assessment of the other patients who shared a bay with them. We observed this patient freely moving around the ward and day unit. This meant there was no consistent approach to infection prevention and control on Gwynne Holford Ward and patients were at risk of contracting an infection.
- At the unannounced inspection a senior nurse told us that written guidance was available. Following the inspection updated guidance was provided to us, including the need for risk assessment, the use of personal protective equipment (PPE) such as gloves and adherence to hand hygiene.
- Hand sanitising gel was available at ward entrances and in bottles at the end of each bed on both wards. There were sufficient sinks. On Mary Seacole ward patients were offered hand wipes prior to meals. We asked staff if they offered or encouraged handwashing before meals; they responded they did not.
- On Mary Seacole hand washing compliance for May 2016 was 96%, for Gwynne Holford Ward it was 78%.The senior nurse told us they were taking action to address the low compliance on Gwynne Holford Ward. During the announced inspection a senior nurse showed us that on Gwynne Holford Ward that the infection control training compliance was 65%.
- Mary Seacole had a board displaying ward specific infection control information including hand hygiene audits. This showed 93% compliance. Gwynne Holford Ward showed 82% compliance.
- There were dedicated staff for cleaning ward areas. On Mary Seacole we observed a bay being 'deep cleaned' with patients being moved from the bay, furniture moved and beds stripped to enable thorough cleaning. Both cleaning staff and nursing staff told us that every weekday two bays were cleaned in this way. Both wards looked clean, and four patients on Mary Seacole commented on the cleanliness of the ward 'very clean, impressed by the cleanliness'.
- Privacy curtains were disposable and these were changed every six months or earlier if they were soiled.
- Cleaning rotas were in place and we observed green 'I am clean' labels on equipment with dates showing they had been cleaned within 24 hours.
- The trust took part in the Patient led Assessment of the Care Environment (PLACE). The survey results for Queen Mary's hospital site gave a score of 100% for cleanliness compared to the England average of 98%.
- We observed that staff adhered to 'bare below the elbows' policy and had access to personal protective equipment (PPE). The wards had appropriate arrangements for managing waste with coloured bags to differentiate domestic or clinical waste.

Mandatory training

- Mandatory training was indicated as a high risk on the trust's community services risk register in February 2016, the division that Mary Seacole came under. It was at risk of not achieving compliance levels due to staff having difficulty accessing the online system. Staff on both wards told us there had been problems in accessing the

online system but there had been some catch up since January 2016. Senior staff on both wards reported that training figures would not be accurate but were aiming for above 85% compliance.

- There were 11 mandatory and statutory sessions. Information on training compliance was provided by the trust in divisions and not individual wards. We were unable to ascertain levels of mandatory training compliance on both wards. In community services mandatory training compliance was 87%, in the neuroscience division, which Gwynne Holford Ward came under it was 74%. In the neurosciences division compliance ranged from 43% for Basic Life Support (BLS) and 57% infection control to 86% for conflict resolution and Equality, Diversity and Human Rights. In community services it ranged from 52% for Immediate Life Support (ILS) training compliance for those who act as first responders and treat until the arrival of a cardiac arrest, to 95% for Health and Safety and Welfare.
- Staff told us that the senior staff and doctors offered 15 minute to one hour training sessions for staff to access on both wards. On Gwynne Holford Ward staff told us it was difficult to attend face to face training due to difficulty in being released from the ward.
- Staff told us that they needed more Immediate Life Support ILS training courses to run.

Assessing and responding to patient risk

- Gwynne Holford and Mary Seacole wards were based at Queen Mary's Hospital, Roehampton and did not provide acute care. Staff on Mary Seacole Ward were able to consistently describe what action they would take if a patient was acutely ill and how to respond in a medical emergency. On Gwynne Holford Ward during our announced inspection staff gave varied responses on what action they would take in the event of a cardiac arrest/medical emergency.
- At our unannounced inspection we saw on Gwynne Holford Ward a printed sheet that had been given to all staff on how to contact a doctor for a medical emergency. It was not clear what situations constituted a medical emergency or need for medical assessment, or which member or grade of staff to be contacted or actions to be done in the meantime while awaiting a response from the medical staff. The process could potentially involve contacting five numbers resulting in delays in getting a medical response to potentially life threatening situations.
- The early warning score trigger tool (EWS) was used on both wards to calculate when patient's observations signified deterioration in the patient's condition and the action to be taken. The initial assessment of the patient indicated how frequently their observations would be undertaken. Trust audits showed that Mary Seacole had variable compliance, while senior staff on Gwynne Holford Ward told us than an EWS audit conducted the month before our inspection showed that improvement was needed in recording EWS. Following our unannounced inspection we received documentation showing the required competencies for staff in managing the deteriorating patient and use of EWS.
- From the 24 EWS charts we looked at on both wards not all the times and dates were recorded accurately. In two EWS charts looked at during our unannounced inspection the two patients had experienced raised scores, one had been in pain and once this was controlled the patient improved. The other patient had a raised EWS at 7.30am indicating they needed a prompt medical assessment. A doctor was not called until 11am. The previous day the patient had reported feeling unwell. Subsequently the patient had to be admitted as an emergency at St George's Hospital. By not recording and acting on EWS appropriately there was a risk that those patients who were deteriorating would not be identified early by the nursing staff, resulting in delays responding to a potentially life threatening condition.
- Following our unannounced inspection we requested written guidance on what action staff would take when a patient absconded as there had been nine incidents in the twelve month period April 2015 to March 2016.The Missing Patients Policy set out an assessment tool, with care plans according to the risk, low or high and a flowchart. Although staff followed the process as set out by the flow chart there was no evidence of the assessment tool or care plan having been used.
- Gwynne Holford Ward used two different formats of care plans. These did not include a review date. Risk assessments and reviews for pressure ulcers and malnutrition were inconsistent. We observed information being shared during handover, however care plans supporting the care of pressure areas or documentation on recording skin integrity were not accurate. They did not reflect the care required or details of skin integrity.

Inadequate

Are services safe?

- On Gwynne Holford Ward during our announced inspection staff were task allocated. For example a member of staff was allocated to filling in food charts, another to completing fluid charts, or completing the EWS rather than being patient centred. This meant there was a fragmentation of care, an absence of holistic assessment or review of individual patient's needs. At the unannounced inspection we saw that staff were now being allocated to patients rather than tasks.
- During our announced inspection we observed the staff handovers. On Mary Seacole there was a verbal nursing handover accompanied by a handover sheet in the nurses' office. This covered brief medical information and the care, pressure areas to be aware of and the support the patient required, and any planned activities that day.
- Staff were allocated according to the need and knowledge of the patient. There was also a daily senior review held for both wards which covered a set criteria including safety performance, and those being monitored or identifying a new need. The nurse in charge had a daily morning handover with the junior doctor and therapy staff to update on future plans.
- During the unannounced inspection we saw that the format and contact of the handover on Gwynne Holford Ward had changed. On the previous visit staff received handover on 46 patients using a handover sheet. They were allocated tasks to undertake and areas to work in. The new allocation comprised of a quick basic history about each patient, then a bedside handover in each bay. The nurse in charge coming on night duty had been on annual leave, she was unaware of the changes to handover and was working with three agency nurses and three health care assistants, and there had been many changes to how the ward was now functioning of which she was unaware.
- The nurse in charge returning from annual leave was advised by the day staff to find information on the 'policy changes. When we asked to see this information they were unable to find it and the matron who was not on shift was called. A discussion between the staff began about the best way to handover, they were concerned about confidentiality. We later spoke with the matron who stated they were trialling this handover. The staff were disorganised, with no guidance about how to implement the new handover. The nurse in charge was expected to implement the change without having time to plan or reflect on its impact on patients.
- The staff did their best to manage the change but without leadership and guidance they were left to work it out for themselves, the nurse handing over was unsure as to its structure. The matron provided us with a copy of the new operational policy dated the 1st July 2016, it did not include information on the handover process. The lack of structure in the handover and the recent substantial changes in the ward meant that there was a risk that critical patient information may be missed and staff would be unsure what processes to follow with the new 'policy changes'.
- We reviewed 11 sets of patient records, an assessment of need was completed on admission including risks such as falls, pressure injury and nutritional risks. We observed thorough assessments completed by physiotherapists, occupational therapists and speech and language therapists with clear goals and actions to achieve them. We found fall risk assessments consistently completed with action and evaluation taken to prevent falls or further falls.
- On Gwynne Holford Ward the standardised recording of patient observations from once in 24 hours to once in 12 hours had been introduced in the last four months in line with NICE guidance on recognising and responding to deterioration
- On Mary Seacole staff monitored patients as part of their intentional rounding, call bells were available and patients were encouraged to ask for help when mobilising. During our inspections call bells were responded to promptly and patients told that most of the time they were able to get the care and support as they needed it.

Staffing levels and caseload

Nursing Staffing

- Information provided by the trust prior to our inspection did not indicate staffing on the neuroscience division risk register. During our announced inspection senior staff from neuroscience told us the risk register had been updated. After the announced inspection we received an addition to the risk register for staffing on Gwynne Holford Ward. This was indicated as a likely extreme risk with catastrophic consequence. There was an overall nursing vacancy level on Gwynne Holford Ward of 46%. There was 40% vacancy at band 6 and 63% at band 5 with nine established staff, one clinical nurse specialist and twelve agency staff.

Inadequate

Are services safe?

- On an action plan provided following our announced inspection seven out of nineteen issues identified on Gwynne Holford Ward were related to staffing. Senior staff reported difficulties in recruiting and retaining band 5 staff. The planned staffing was six registered nurses and seven health care assistants for 7.30am to 8pm and at night four registered nurses and three health care assistants. On the safe staffing rota over the last year there had been more agency registered nurses than permanent staff on 90% of the shifts, there were only a few shifts were there was the full complement of registered nurses recorded. On average there were three to four health care assistants on day shifts and at night two. Night staff on average were a total of five to six staff, more of registered nurses than health care assistants. There was an ongoing block booking of agency staff which had started five months before our announced inspection. Staff told us that when they requested the additional staff to support patients who required 1:1 support at times these requests were refused. Some staff spoke of senior staff not being aware of the effect of not having enough staff to provide appropriate care. The ward was not using staff acuity tools to determine or adjust staffing levels. The level of support individual patients required varied greatly, this was not considered in staffing numbers and the skills required. This meant the trust could not be assured that it was delivering safe care provided by sufficient staff with the appropriate skills.
- Three incidents recorded for Gwynne Holford Ward were related to staffing, one was a patient not washed and dressed in time for gym session and two about insufficient staff and calling for help but there not being the staff to assist them. Patients had reported the staff 'they are rushed off their feet' 'unable to help as so short staffed' 'not isolated ongoing concerns about insufficient staff on unit'.
- There was no practice educator allocated to Gwynne Holford Ward. Staff told us there were not enough substantive staff to support caring for patients on two levels. Due to the staffing vacancy the matron had had to resort to task allocation and had moved away from named nursing. At the unannounced inspection we were informed and saw on the action plan that a band 7 practice educator was being recruited.
- There were eight incidents 'alerts' recorded by the trust for inadequate staffing levels between August 2015 and March 2016 on Gwynne Holford Ward and there were two 'alerts' for Mary Seacole
- Staff on Gwynne Holford Ward told us that they needed a ward manager. Following the inspection, we were told by the trust that efforts had been made to recruit a ward manager but this had been unsuccessful. At our unannounced inspection, a ward manager from a neurology ward had been allocated to the ward and had started three days previously.
- Mary Seacole Ward had two nursing teams. The planned staffing being four registered nurses and three health care assistants on a team during the week day shifts, at weekends three registered nurses and three health care assistants and two registered nurses at night with three health care assistants. There was a sister on each team and a seconded matron for the two teams. On Mary Seacole, senior staff told us that over a year ago they had 50% vacancies but now they had three vacancies across the two teams and used a few agency staff who were part of the team. They had recently recruited three new band 5 nurses. The ward was using the RCN Older Persons nurse patient ratio 1:7 day and 1:10 night and from the safe staffing rota this was being met. Staff told us they were able to have staff to support patients who had been identified as requiring 1:1 support, we saw one person who required and received this support.

Medical Staffing

- Consultants were available weekdays 9-5pm. Outside of these hours a named consultant was available to be called from 5pm until 9am the next day and at the weekend, anytime. Junior doctors were available weekdays 9-5pm. There was a junior doctor on-call who provided cover from 5pm-8pm weekdays, and 9am-5pm weekends. When no junior doctor was on-call, the nurses would contact St George's emergency team. If patients were acutely unwell, they were transferred to St Geroge's emergency department.
- One locum amputee rehab consultant was employed, one clinical nurse specialist and a range of allied health professionals including physiotherapists, occupational therapists and a psychologist. However, information provided after our inspection cited a lack of long term expertise for patients with limb amputations who used the service.

Inadequate

Are services safe?

Therapist Staffing

- On both wards patients were receiving support from therapists such as physiotherapists, speech and language therapists, occupational therapists and rehab assistants. Some patients on Gwynne Holford Ward had acquired brain injury and the numbers of therapists were well within the guidelines set by the Royal College of Physicians 2003 of one occupational therapist and physiotherapist plus support staff per five beds. We saw that patient on both wards were assessed on admission by therapists with clear goals and reviews.

Managing anticipated risks

- The wards were on the lower ground floor with exits onto level ground. The trust had an emergency preparedness, resilience and response policy dated May 2014 with a review overdue. It set out what to do in the event of a major incident. In documents we looked at, there was no business continuity plan that set out what actions the community inpatient unit would take.

Requires improvement

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

We rated effective as requires improvement because:

- Bed rails were used for many patients, without it being discussed and there being any clear indication for their use. There had been no consideration by staff that the use of bed rails was a form of restraint and was possibly depriving patients of their liberty.
- The implementation of evidence-based care was variable on Gwynne Holford Ward. For example, there was no evidence of best practice guidelines on catheter care.
- There was no evaluation of patients pain, nor was it discussed at handover on Gwynne Holford Ward.
- Not all the staff had the right qualifications, skills knowledge and experience to do their job.
- There were gaps in management and support arrangements for staff such as supervision and professional development.
- Agency staff could not access information from the intranet for policies and other trust information.

However:

- There was excellent multidisciplinary working.
- There were clear referral processes and both wards aimed in their rehabilitation programmes to maximise the functional and physical ability of the patient.

Evidence based care and treatment

- Protocols had been introduced to limit the range of prostheses for patients who had limb amputations and secondary limbs. There had also been policy changes in providing a minimum level of walking training to patients.
- We reviewed patient notes on Gwynne Holford Ward and found that there was inconsistent use of guidelines for preventing malnutrition. There was no evidence of best practice guidelines on catheter care. Most of the patients had bladder and bowel needs, but there was no evidence in the care plans of bowel management plans or specific catheter care. This meant that care for patients was not consistently planned or monitored and that if their condition deteriorated there may not be an appropriate response.
- At the time of our announced inspection on Gwynne Holford Ward, the records were fragmented, care had been task rather than patient orientated and there was no holistic overview of a patient. However, during the unannounced inspection, we saw that records had been brought together and care was patient centred rather than on tasks to be completed. A named nurse system had been introduced as advised by the Department of Health (DH), the Royal College of Nursing and National Institute for Health and Care Excellence (NICE), who recommend patient-centred care to improve outcomes and patient experience.
- At the unannounced inspection on Gwynne Holford Ward during the handover, we observed staff were unsure how to organise it and it was unstructured. An evidence based tool was not used to structure the information being shared.
- On Mary Seacole Ward, we saw good use of tools such as the Malnutrition Universal Screening Tool (MUST) and the Waterlow Pressure Ulcer Risk Assessment Tool. A protected meal times audit in May 2015 had indicated that MUSTs had not been completed correctly, but staff told us that and we saw good compliance in completing these.
- Therapists on both wards used a patient-centred approach in their assessments and therapy focused goals with patients. Meetings and records showed nurses were minimally involved in the goal planning.
- The Situation Background Assessment Recommendation SBAR tool was used by staff when a patient was being referred to Mary Seacole Ward. This is a nationally recognised tool to structure and improve information sharing. This tool helped clarify the information needed to ensure that the patient had rehabilitation potential and was an appropriate admission. On Mary Seacole Ward, patient's needs were assessed and care and treatment was delivered in line with NICE quality standards relating to malnutrition.

Requires improvement

Are services effective?

- On both wards, we found care folders which contained evidence based guidance. Staff told us there could be delays in accessing the intranet where policies were available and agency staff did not have access to the computers.
- Audits were regularly undertaken for protected mealtimes and use of the MUST tool. Safety performance on UTIs were collected and discussed daily within the senior nurse reviews, held jointly between the two wards.

Pain relief

- Staff discussed the need for pain relief with patients and we saw evidence of therapists undertaking pain assessments. Of the 18 patients we spoke with, two told us that they had had to wait for medicine to control their pain. Two incidents were recorded on Gwynne Holford Ward for delayed pain control medication in the last year. During our unannounced visit, a registered nurse (RN) explained about a patient who experienced moderate, expected pain during rehabilitation, who wasn't prescribed analgesics. The patient had pain in the evening. There was some delay in prescribing and administering the analgesics. The process followed, was to bleep a doctor and the analgesics were administered using a verbal order.
- Some medicine administration records (MAR), did not include times when medicines were given, therefore we could not establish if patients received regular medicines on time or whether delays were actioned or reported.
- On Gwynne Holford Ward, we could not find guidelines about pain assessment in the patient's records. Pain was not identified as a potential problem for 10 patients on their care plan, when it could be a potential problem for all patients, and evaluation of pain was not documented by nurses. Two RNs said they knew about the different types of pain; (e.g. acute, neuropathic) and they used a 1-10 pain score. However, we did not observe that patients pain being discussed at handover.

Nutrition and hydration

- The trust took part in the Patient led Assessment of the Care Environment (PLACE). The survey results for the Queen Mary's Hospital site gave a score of 93% for the food compared to the England average of 89%.
- On Mary Seacole Ward, we saw consistent good use of the MUST which was used to assess the patient's risk of malnutrition. This was used during a patient's initial assessment in line with NICE guidance on nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition.
- On Mary Seacole Ward, protected mealtimes allowed patients to eat their meals without disruption and enable staff to focus on assisting those who required help with their meals.
- Patients were complimentary about the food, there was a dedicated hostess for the ward and meal times, who ensured the food was the appropriate temperature before serving it. There was a mealtime champion who ensured that people were comfortable, that all patients got their trays of food and had assistance if they needed it.
- We observed patients being prepared for meals and sitting together at tables in their bays and in the dining room. Staff encouraged and assisted patients as they needed with their meals. Volunteers joined patients at lunchtime to encourage the social elements of mealtimes.
- Speech and language therapists carried out thorough assessments and set out guidelines to ensure patients received their food and fluids safely.

Patient outcomes

- The average length of stay on Gwynne Holford Ward was 12 weeks and for Mary Seacole Ward it was two to three weeks.
- Gwynne Holford Ward, as part of a nationally recognised rehabilitation centre, submitted data on admission, discharge and every two weeks during the patients admission. The outcome measures on admission and discharge included a rehabilitation complexity score (RCS), functional independence measure (FIM), functional assessment measure (FAM), a neurological impairment set, a Northwick Park therapy dependency assessment and a Northwick Park rehabilitation nursing assessment. This measured the type of patient being treated, the intensity of therapy being provided, the therapies involved and tracking the patient's progress. This information was sent to the specialist Rehabilitation Outcomes Collaborative (UKROC), which was set up in September 2008 through a Department of Health (DH) initiative to develop a national database for

collating case episodes for inpatient rehabilitation. Accredited as a rehabilitation unit, the team at Gwynne Holford Ward had to submit data every two weeks to UKROC.
- On Mary Seacole Ward, the therapists used focus goals to increase patient's mobility.

Competent staff

- At the time of the announced inspection, there was no practice educator on Gwynne Holford Ward. At the unannounced inspection, we were told and saw documents that confirmed the post was being recruited to.
- Staff on Gwynne Holford Ward told us and we saw that some staff did not have the skills and competencies to respond to patients with complex neurological needs or to the deteriorating patient who needed prompt medical attention. Staff told us they had concerns about staffing and the challenging needs of patients, but that this had not been fully taken on board by senior staff.
- On Gwynne Holford Ward, there was a clinical nurse specialist with expertise in bladder and bowel, but no specialist rehabilitation nurses. On Mary Seacole Ward, there were MDT staff members with expertise in bladder and bowel care as well as elderly rehabilitation.
- Staff told us that some of the patients had complex and challenging needs and that patients with more complex behavioural issues related to their conditions were being admitted.
- During weekdays, nursing staff could seek advice from the specialist doctors, but there had been incidents at the weekend where they had been unable to get specialist advice and had been concerned about the safety of the patient and the emotional wellbeing of other patients. A series of study days on managing challenging behaviour had been organised and we saw that 20 staff members had signed up to attend.
- Staff on Gwynne Holford Ward were not receiving clinical supervision. The action plan provided after our announced inspection reported that funding for clinical supervision was being confirmed. Staff on Mary Seacole Ward shared learning as it happened and in monthly team meetings, but staff did not have regular one to one supervision sessions.
- Staff on both wards told us the doctors provided short training sessions on the ward for staff to attend. This included 20 minute slots held during an afternoon, to make it more convenient for staff to attend.
- Some staff told us there needed to be more structured learning on Gwynne Holford Ward. During our announced inspection, staff reported they were mentoring student nurses. The nursing students were supposed to be supernumerary, but 90% of the time they worked in a bay and would be closely observed by their mentor. The ward was short of two mentors, but staff reported that students were able to access learning opportunities and be observed by their mentor.
- However, we saw in the safe staffing rota, students were included in the staff available. The NMC (2010) standards for Pre-Registration Education states student nurses are supernumerary through their undergraduate programme and must have learning identified by their mentors and be observed directly or nearer to the end of their degree indirectly.
- On Gwynne Holford Ward 80% of staff had received their appraisals, whilst on Mary Seacole Ward, all the staff had received their appraisals.
- There was a trust induction day for new staff which included infection control, pressure ulcer management, documentation and care planning, nutrition, the Mental Capacity Act and multi-disciplinary team working.
- On Mary Seacole Ward, staff told us they received a good induction from the ward. Induction was a formal part of each new starter's timetable, however, on Gwynne Holford Ward senior staff told us there had not been a new starter for two months.
- Agency staff told us they had been working on the wards for some time and worked there regularly. They reported they had been oriented to the ward, received information about patients during handover and were able to access the patients' records. They were not able to access the intranet, electronic incident reporting system or emails.
- Staff told us that there were not always the opportunities for development and progress in the organisation.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary team (MDT) working was well established on both wards and formed an integral part of the wards.

Requires improvement

Are services effective?

- On Gwynne Holford Ward, we observed an MDT meeting where each patient was discussed individually across the team. Each discipline was represented and had an opportunity to discuss patient outcomes. Outcomes discussed were psychological, emotional, bladder, bowel, physiotherapy and occupational therapy goals. Patients were allocated a key worker. Also discussed in this meeting were safeguarding and review dates for those subject to Deprivation of Liberty Safeguards. This information was then disseminated to the nurses.
- On Mary Seacole Ward, therapy staff and doctors had a daily meeting with the sister on the ward after the nurses' handover. This information was then shared with the nursing staff. Consultants on the ward attended the MDT meetings for the community ward as part of the management of community patients with complex care management needs within community adult health services. This enabled more effective planning for discharge.

Referral, transfer, discharge and transition

- At the time of our announced inspection, there had been 23 delayed discharges on Mary Seacole Ward between January 2016 and June 2016, most had been due to social issues. On Gwynne Holford Ward, delays in discharge were caused by patients waiting to go to specialist inpatient facilities, or awaiting funding sources for home discharge, as was the case for two patients during our announced inspection.
- If patients were acutely unwell, they would be transferred to the emergency department at St George's Hospital.
- Patients were referred to Gwynne Holford Ward with either high or moderate complexity rehabilitation needs. The referrals were triaged into different clinics with different specialists for MDT assessment. These patients were assessed, with the outcome being either, suitable for admission, suitable for admission pending the resolution of medical issues or other factors, or not suitable for admission but suggestions made regarding more suitable services to access.
- For admission to Mary Seacole Ward, patients had to be above working age, to be medically stable, for rehabilitation and to be able to be discharged home. Referrals were either received from St George's or three other hospitals or via the patient's GP. A relatively small number of referrals came via the patient's GP, who rang or sent a fax using the SBAR communication tool or the local acute trust's acute admission avoidance pathway. Reminders about criteria for admission were sent via the trust's newsletter to colleagues in primary care. The aim was to provide a multidisciplinary inpatient rehabilitation service which focused on maximising the functional, physical ability of the patient.
- The discharge co-ordinator on Mary Seacole Ward worked closely with the local authorities, the consultants, St George's Hospital and the MDT in planning discharges. Discharge planning commenced when patients were admitted to the ward. Records and conversations with patients and staff demonstrated discharge was discussed when patients were admitted. Occupational therapists undertook home visits in discharge planning**.** Patients received leaflets including fall prevention.

Access to information

- Patients on both wards had paper records. At the announced inspection on Gwynne Holford Ward, the charts and records were fragmented and located on different levels and this made it hard for staff to get an overview of the patient. However, by the time of the unannounced inspection, the records were located in one place and staff could easily access them. On Gwynne Holford Ward, the patient records were not consistently organised in a structured way, this made it harder to find certain information about the patient's needs.
- Permanent staff were able to access emails, electronic files and the trust intranet. Bank and agency staff did not have access. On Gwynne Holford Ward, this meant that about half of the staff working on the ward did not have access to the email system or the intranet which contained the trust's policies. This meant there was a risk that staff may not receive or access information related to patient care.
- On Mary Seacole Ward, patients with living dementia had copies of 'This is me' documentation. This is a tool for people with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.
- Discharge information from Mary Seacole Ward was emailed and posted first class to the patient's GP.

Requires improvement

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw on Mary Seacole Ward that bedrails were used on most of the patient's beds. On Gwynne Holford Ward, three patients were identified as using bedrails. We looked at a selection of these patients' notes, the policy for the safe use of bedrails and spoke with three patients to establish whether bedrails were being used appropriately. The patients we spoke with had not had the use of bedrails discussed with them and the records had no clear indication as to why they were being used. There had been no consideration by staff that the use of bedrails was a form of restraint and was possibly depriving them of their liberty.
- Staff had received training on the Mental Capacity Act (2005) (MCA) in relation to seeking patient consent prior to significant decisions.
- We observed some patients being asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were sometimes followed to ensure decisions were made in the best interests of patients. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
- There were three patients across the two wards who were under a deprivation of liberty safeguard (DoLS). Staff had followed the process, such as a referral being made to the local authority for assessment. Staff discussed the timescale for a review of a deprivation of liberty safeguard application and were aware that it was time limited to safeguard patients.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as 'good' because:

- Patients were positive about the care and support they received and for both wards the friends and family test scored 100% in extremely likely to recommend.
- People were treated with dignity and respect and relationships with staff were positive.
- People valued the rehabilitation activities they took part in.

However:

- Some patients did not feel they had someone they could talk about their worries with.

Compassionate care

- We observed patients received caring and compassionate care which was centred on them. Patients were mostly positive about their care and treatment.
- Patients told us 'the staff are amazing, very caring, cannot fault the staff '. Patients described the staff as 'very kind and caring', 'tremendous'. However, one patient reported that some staff 'did not listen' and another that 'some staff were grumpy as if they didn't want to be there'. Two patients told us at night there could be slight delays in getting help as it was busy.
- Care was provided in six bedded bays and single rooms. Each bay was single sex accommodation in accordance with national guidance.
- We saw staff closing curtains and doors when providing care to protect patient's privacy and dignity. Patients told us that their privacy was protected.
- The friends and family test score for Gwynne Holford Ward for May 2016 showed 100% would be extremely likely to recommend the ward, with 87.5% for enough privacy.
- The friends and family test score for Mary Seacole Ward for June 2016 showed 100% would be extremely likely to recommend the ward, with 94% for enough privacy.
- Staff we spoke with were committed about the care and treatment they provided and we saw positive interaction with patients on both wards.
- Patients and staff told us there was a volunteer who visited Mary Seacole Ward with a dog which patients enjoyed. There were music sessions when a member of staff played their guitar and patients sang.
- However, information received after our inspection reported that staff could be overheard in a waiting area discussing patients' test results so breaching individual patient's confidentiality.

Understanding and involvement of patients and those close to them

- Patients on both wards told us they were involved in their care and kept informed by staff. Many patients told us they were pleased with the progress they were making. Patients told us they were 'pleased about the physiotherapy helping them to recover' and staff had 'a schedule with activities created for me and helping me recover'.
- The friends and family score for Gwynne Holford Ward in May 2016 was 62.5% for being involved in care as much as I want to be; on Mary Seacole Ward the score was 94%.
- However, staff on Gwynne Holford Ward told us that due to the shortage of staff, they were doing tasks for patients rather than encouraging them to do it themselves as 'we can do it ourselves quicker'. This included getting patients out of bed in the morning. Staff said they were not rehabilitating the patients with their needs, rather they were doing it for the patients because it was faster.

Emotional support

- On Gwynne Holford Ward, we observed that staff had developed strong therapeutic relationships. Psychological and psychiatric support was available Monday to Friday 9am to 5pm.
- On Gwynne Holford Ward, the trust's friends and family test scored 50% for patients having someone they could talk about their worries with. On Mary Seacole Ward, the score for this question was 92%
- On both wards, we observed staff talking sensitively with patients, taking into account their emotional needs.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsive as 'requires improvement' because:

- Services were not always delivered in a way that focused on people's holistic needs.
- The premises used by Gwynne Holford Ward was not appropriate for the service provided and at the time of our unannounced inspection, suitable action had not been taken to address this.
- Due to the layout of the premises care was fragmented.

However:

- The service had learnt from a complaint and had made changes in response to it with the issues highlighted having been resolved.
- There were appropriate facilities including safe and level access for patients and visitors with limited mobility.

Planning and delivering services which meet people's needs

- During our announced inspection on Gwynne Holford Ward, we found that patients and staff were moving between the two levels. Although patients were able to freely access the day unit on the ground floor, the layout and arrangements for medication and records meant care was fragmented. The administration of medication was not robust and staff were not able to monitor the well-being of patients. Staff told us that working across two levels meant it was hard to observe patients and that patients had absconded. There had been nine incidents recorded for patients absconding.
- Staff told us patients with more challenging needs were being admitted and that it was difficult to meet their needs and protect the emotional wellbeing of other patients.
- Gwynne Holford Ward provided rehabilitation and support for adults who had had limb amputations or who required neurorehabilitation. Patients needed to be medically stable. Ten beds were allocated for adults who had had limb amputations and 36 beds for those requiring neurorehabilitation. It was accredited as a rehabilitation unit for patients with either high or moderate complexity rehabilitation needs. The service was commissioned based on the mix of patients, the complexity of need, staffing levels, the facilities and the feedback to NHS England and the CCGs regarding the type of neuro-rehabilitation they were are doing.
- A consultant told us that there was a shortage of neurorehabilitation units in London. The number of beds on the ward had expanded from 18 beds at our last inspection in 2014 to 28 beds and then to 46 beds in April 2015. The increase in beds had come from a restructuring of services with the closure of a neuroscience hospital and a neurorehabilitation unit and a plan to develop an expanded ward with rehabilitation assessment.
- Mary Seacole Ward provided 42 beds rehabilitation for older people who were medically stable. The aim was to provide a multidisciplinary inpatient rehabilitation service which focused on maximising the functional, physical ability of the patient before returning home. From 21 January 2016 until the 15 April 2016, 20 beds had been provided at Nightingale House to support winter beds. The ward worked closely with the local authorities, GPs and community nurses and there was agreed admission criteria and discharges, which were well co-ordinated. Senior staff told us that criteria for admission to the ward was adhered to. A senior nurse would visit a patient if necessary to assess their suitability for rehabilitation on Mary Seacole Ward.
- Patients from both wards used the rehabilitation facilities in the gym on the ground floor with guidance from therapists.

Equality and diversity

- Training in equality and diversity was provided in the neurosciences division, where Gwynne Holford Ward came under and 86% of staff attended in the past year. In the community division where Mary Seacole Ward came under, staff attendance with this training was 90%.
- There were appropriate facilities including safe and level access for patients and visitors with limited mobility. These included designated parking and toilet facilities to accommodate patients and visitors in wheelchairs.
- Care practices observed showed staff were aware of people's diverse needs and supported them with respect.

Requires improvement

Are services responsive to people's needs?

- Staff were aware of different dietary needs of patients and ensured they were provided.
- Staff were able to access a telephone interpreting service. However, information leaflets in languages other than English were not available on the two wards.

Meeting the needs of people in vulnerable circumstances

- We saw in patient's notes and heard patients completing the Mini Mental State Examination (MMSE) as part of the assessment of patients' mental and physical needs being considered on Mary Seacole Ward.
- A checklist was used for patients living with dementia to ensure their needs were met and we saw a patient on Mary Seacole Ward had a copy of 'This is me' documentation. This tool informed health and social care professionals of the person's needs, interests, preferences, likes and dislikes.
- During our announced inspection, patients from Gwynne Holford Ward had their meals in the day unit. At the unannounced inspection staff and patients told us that breakfast was served on the ward and patients ate at their bedside table. Lunch and the evening meal were provided in the public restaurant on the lower ground floor.
- A red tray system was used to identify patients who needed help and support from staff with meals. However, there was no information in the patient's records and there was no information about the logistics of this, given that two meals were eaten off the ward.
- Some patients on Gwynne Holford Ward did not like eating near their bed, as they felt there was not enough space to do this in comfort. They preferred to go to the restaurant for lunch and the evening meal. We were told at the unannounced inspection that there was a member of staff allocated to be the mealtime champion and to encourage and observe patients at meal times.
- Three patients at the unannounced inspection told us they did not like the new arrangements of only going to the day unit for rehab sessions and felt it was inhibiting their rehabilitation. Patients described feeling 'coralled' or penned in. Patients we spoke with during the unannounced inspection told us that they had not been consulted about the changes. Documents provided by the trust following our unannounced inspection showed that patients had been informed about the changes prior to our unannounced inspection, however concerns about having meals at the bedside and 'feeling too confined to the ward' were not responded to.

Access to the right care at the right time

- At the time of our announced inspection on Mary Seacole Ward, there had been 23 delayed discharges since January 2016 with most being due to social issues, such as delays in packages of care at home.
- Information received following our inspection reported there were delays in medical letters being typed and responses to telephone calls for those patients with limb amputations using the service.
- Delayed discharges from Gwynne Holford Ward were those patients awaiting for funding of packages of care.
- The bed occupancy within the community inpatients was similar to the national average of 89%. It is generally accepted that bed occupancy above 85% level can start to affect the quality of care provided to patients.
- The average wait to be admitted to Gwynne Holford Ward for rehabilitation was four to six weeks. Staff told us there were high levels of need and during weekends and evenings when there were no senior nurses and there was limited medical cover. There had been incidences when staff had not been able to access timely professional expertise and guidance.

Learning from complaints and concerns

- Patients using the rehabilitation service for those with limb amputations, reported that they were not aware of the complaints or compliments procedure being publicised to patients.
- A patients' user group reported being 'tolerated by hospital and not valued as a positive force and encouragement for other amputees and a help to staff'.
- Between April 2015 and March 2016, there had been four letters of complaints for Mary Seacole Ward and one for Gwynne Holford Ward. One letter set out major problems on Mary Seacole Ward that the relative had identified. These were responded to and had been addressed. As a result, the ward was run with two teams rather than one and issues related to the attitude of some staff towards patients and in medicine administration had been resolved. Major changes had been implemented, senior nurses stated they were thankful for the complaint and had seen improvements in the care provided.

Requires improvement

Are services responsive to people's needs?

- Patients we spoke with said they felt confident to make a complaint and believed it would be taken seriously.
- We saw Patient Advice Liaison Service PALS leaflets available on the wards.

Inadequate

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well-led as 'inadequate' because:

- Significant issues that threatened the delivery of safe, effective care had not been identified and adequate action to manage them had not been taken.
- The impact of service changes on the quality of care had not been understood.
- There was not effective senior leadership on Gwynne Holford Ward and they were out of touch with what was happening on the ward.
- There were high levels of staff stress on Gwynne Holford Ward and work overload.

However:

- Staff felt valued by their peers, matrons and ward managers. Staff had a strong focus on providing compassionate care.
- Matrons and ward managers were working to manage the service and support their staff.

Service vision and strategy

- Our conversations with senior medical and nursing staff responsible for Gwynne Holford Ward, revealed there was no clear strategy for the service.
- Issues that we identified and that were known about had not been addressed by senior managers. For example, nursing care was task orientated, staff were working across two floors, there was fragmentation of records, staff were not able to monitor patients safely and the administration of medication was not robust. Nursing staff on the ward spoke of challenges in caring for patients with increasingly complex needs and that they did not have the skills and competencies to do this safely.
- An action plan provided after our announced inspection set out 22 action points with major changes on the day to day running of the ward and some longer term plans.

Governance, risk management and quality measurement

- In Gwynne Holford Ward, staffing had been added as a new risk in May 2016, although there had been substantial vacancies for a year. Although there was inadequate staffing, there was little evidence at the time of our announced inspection, that actions had been taken to minimise risks to patients.
- In the planning of the expansion of Gwynne Holford Ward, there had been no risk assessment, although the deficit in nursing staff was known.
- The action plan for Gwynne Holford Ward provided following our announced inspection set out major changes and plans for the ward.
- During our unannounced inspection we saw three of the 22 points had been actioned. This had involved major changes in the environment and how care was provided. However, this appeared to have been reactive and not fully considered.
- Many aspects of the action plan and risks associated with the changes had not been fully considered. Patients told us during the unannounced inspection they had not been consulted about changes and logistics in the lunch and evening meal arrangements, these had not been fully thought through. There was a plan for recruiting staff with a temporary measure of reallocating staff, but the risks associated with this had not been considered. There appeared to be a lot of reactive change, but minimal structure to mitigate against risks to patient safety.
- We saw action plans and minutes from meetings attended by senior staff responsible for both wards. Ward managers were supervised by the matron who was supervised by the head of nursing for either neurosciences, Gwynne Holford Ward or community services and Mary Seacole. Information from board level was cascaded through the head of nursing from the divisional director of nursing and governance (DDNG) who attended the patient safety committee, the patient experience committee, the organisational risk committee and the policy ratification group. These groups then reported into quality and risk committee which reported to the trust board. The two heads of nursing for Mary Seacole and Gwynne Holford Ward met monthly. The matron or ward manager shared information with staff in team meetings.

Inadequate

Are services well-led?

- A trust risk register and risk registers for the community services division and neuroscience directorate were kept.
- Risks we identified on Gwynne Holford Ward were not listed on the divisional or trust risk register.

Leadership of this service

- On Gwynne Holford Ward, a matron had started on secondment four months before our announced inspection. There had been substantial vacancies and a lack of leadership. This secondment had been initially for four months, but was extended to six months. Following our announced inspection, this post was to become substantive. The matron had brought in evidence-based practice and introduced staff meetings. The appraisal rate had risen from 35% to 80%. The lack of substantive staff, electronic patient records and integrated documentation adversely impacted on the ability to provide safe care to patients across two levels.
- The staff did their best to manage the change that was implemented following our announced inspection, but without leadership and guidance, they were left to work it out for themselves. There appeared to be a lack of senior leadership and understanding of the challenges on Gwynne Holford Ward and there had been minimal intervention from senior staff since the number of beds increased.
- The action plan generated by senior staff following our initial inspection, contained some immediate nursing actions. The plan was reactive and involved the immediate implementation of change. There was no strategic plans to improve quality, safety and staffing of Gwynne Holford Ward. There was no 'Big Picture' and this was evidenced by actions prematurely RAG rated as green which indicated the action had been completed.
- Planning to implement and support staff around change was not documented. Consideration to budgetary, environmental or process constraints was not evident and there was no documentation of patient involvement in the action plan. Measurements to assess the impact of change against outcomes was not documented.
- On Mary Seacole Ward, staff spoke positively of the leadership of the service and that the leaders had the necessary skills, experience and integrity.

Culture within this service

- Some staff spoke of low morale Gwynne Holford Ward.
- For community inpatients nursing staff which Mary Seacole Ward came under, the sickness rates for the last year was 2.70%, for medical staff 0.30%. For the division in which Gwynne Holford Ward came under, the nursing sickness rate was 3.47%, for medical staff it was 1.24%.
- Staff felt valued by their peers and by their matrons and ward managers. Staff had a strong focus on providing compassionate care.
- Nursing staff told us they would raise any concerns about the quality of care with senior staff. However, these staff were not aware of who else they should raise concerns with if they felt unable to raise them directly with their line manager. Senior staff reported that concerns were raised with their head of nursing. A whistleblowing, raising concerns policy was seen in the wards' care communication folder.
- Staff working on Mary Seacole Ward were positive about working on the ward, they acknowledged there had been problems with staffing and the way they had delivered care in the past, but felt the ward now worked well run as two teams.

Public engagement

- The matron on Gwynne Holford Ward had implemented a suggestion box for patients to write in their concerns anonymously. She had made changes based on the patients concerns, she said the patients had concerns about delays in medication which led to the installation of the PODS downstairs. However, this was only available to those patients who could write; patients with sensory deficits were not able to use the suggestion box.
- On Gwynne Holford Ward, a monthly patient- public involvement meeting took place on the first Thursday of each month. In minutes of this meeting, we saw that patients' views were asked but did not shape or influence plans for the service.
- Mary Seacole Ward had volunteers who visited the ward and had just started a monthly afternoon tea event inviting back patients to listen to their experiences, suggestions and to 'walk round' with a senior nurse. There was no feedback available from this new event.
- Patients from Mary Seacole Ward had been involved as assessors in the PLACE survey, assessing the cleanliness, food, privacy, dignity and facilities of Queen Mary's Hospital.

Inadequate

Are services well-led?

Staff engagement

- Staff had taken part in the trust's NHS staff survey, however the results were not available solely for the two wards.
- Staff we spoke with on both wards had not participated or been invited to participate in forums on how to improve the patient experience.
- We found a marked lack of engagement from staff on Gwynne Holford Ward, who had not been happy with the lack of consultation and their involvement with the recent changes.

Innovation, improvement and sustainability

- Information collected by the trust was not robust and audits were not consistently used to identify how practice could be improved.
- The consultants working on Mary Seacole Ward attended community ward rounds in various community hubs where they met with Community Adult Health Services (CAHS) teams in planning more complex care. The CAHS was made of GPs, advanced nurse practitioners, specialist nurses, physiotherapists, occupational therapists, speech and language therapists, social workers and support staff from health and voluntary sectors.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes were not established and operated effectively to ensure compliance with the requirements of the regulation because:** • **Significant issues that threatened the delivery of safe, effective care had not been identified and adequate action to manage them had not been taken.** • **The impact of service changes on the quality of care had not been understood.** • **There was not effective senior leadership on Gwynne Holford Ward and they were out of touch with what was happening on the ward.** • There was no clear strategy for the service on Gwynne Holford Ward. • Incidents were not consistently reported or acted upon on Gwynne Holford Ward and opportunities to learn from these and improve care were missed. • In the planning of the expansion of Gwynne Holford Ward, there had been no risk assessment, although the deficit in nursing staff was known. • Risks we identified were not listed on the divisional or trust risk register. For example, there were no risks identified for Mary Seacole Ward directly. • There was a lack of urgency by nursing staff to get the deteriorating patient medically assessed. • Medicines were not always prescribed and administered safely and in line with the trust's policy and national guidance. • There was no consistent approach to infection prevention and control on one of the wards, along with poor compliance with hand hygiene and infection control training. • There were low rates of basic life support training. • The implementation of evidence-based care on Gwynne Holford Ward was variable.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed because: 1. There were substantial staff shortages on Gwynne Holford Ward and this increased the risk of harm to patients. 2. On the safe staffing rota over the last year, there had been more agency registered nurses than permanent staff on 90% of the shifts and only a few shifts were there was the full complement of registered nurses required. 3. The wards were not using staff acuity tools to determine or adjust staffing levels. 4. There were eight incidents 'alerts' recorded by the trust for inadequate staffing levels between August 2015 and March 2016 on Gwynne Holford Ward and there were two 'alerts' for Mary Seacole Ward. Regulation 18 (1)

Regulation 17 (2) (a), (b)