

Requires improvement 

West London Mental Health NHS Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL14	Lakeside Mental Health Unit and Hounslow community services	Finch Grosvenor Kestrel Kingfisher	TW7 6AF
RKL79	Hammersmith and Fulham Mental Health Unit and community services	Lillie Ravenscourt Avonmore Askew (PICU)	W6 8NF
RKL53	St Bernard's and Ealing community services	Hope Horizon	UB1 3EU

Summary of findings

This report describes our judgement of the quality of care provided within this core service by West London Mental Health NHS 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 West London Mental Health NHS Trust and these are brought together to inform our overall judgement of West London Mental Health NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Inadequate



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	12
Our inspection team	12
Why we carried out this inspection	12
How we carried out this inspection	13
What people who use the provider's services say	13
Areas for improvement	14

Detailed findings from this inspection

Locations inspected	16
Mental Health Act responsibilities	16
Mental Capacity Act and Deprivation of Liberty Safeguards	16
Findings by our five questions	18
Action we have told the provider to take	40

Summary of findings

Overall summary

Following this inspection, we rated acute wards for working age adults and the psychiatric intensive care unit (PICU) as **requires improvement** because:

- At this inspection we found the trust had made considerable progress from the previous inspection in June 2015 but in some cases this was not yet fully completed or embedded. There were some areas where we have asked the trust to do some further work and some new areas for improvement have been identified.
 - The trust had made improvements to the location and environments of seclusion rooms, but further improvements to the location of seclusion rooms were needed at Hammersmith and Fulham and Lakeside. Also the seclusion room on Finch ward required some repairs to the environment.
 - The trust had implemented a new ligature management policy with a range of actions to reduce the risks from ligature anchor points across the trust. Considerable work had already taken place but some further work was needed to ensure the new approach was fully embedded and these risks had been reduced as far as possible.
 - Work had taken place to improve patient risk assessments but these records were not always being updated following incidents.
 - Work had taken place to improve the safety of medicines management but fridges used for the storage of medication were not always in the correct temperature range and this was not being addressed.
 - Patients were admitted to acute wards and then sleeping on rehabilitation wards, especially at St Bernard's in Ealing. This was not safe or appropriate practice. We have therefore rated the responsive domain as inadequate.
- Staff were not all receiving an appraisal or regular individual supervision. The quality of the supervision was not monitored.
 - Junior doctor out of hour's rotas needed to be reviewed to ensure they were safe.
 - Ward managers did not have access to clear and accurate information in a user-friendly format that monitored the quality of the service being delivered on each ward and identified where the ward was an outlier and improvements needed to be made.
 - The trust had carried out a great deal of work to improve the physical health assessment of patients though there were some gaps in the consistency of physical health monitoring.
 - Care planning was not consistently recovery focussed and the patient views, goals and aims were not included in all care plans.
 - Access to psychology services was limited across the service and not all patients were receiving prompt psychological assessment and intervention.
 - Some ward environments, especially at St Bernard's did not provide an appropriate therapeutic environment due to the ward layout and lack of communal space.

However:

- Many patients spoke positively about the service and many staff engaged pro-actively with patients.
- Staff said that since the last inspection in June 2015, staff morale had improved.
- Considerable work had taken place to improve areas such as assessing and monitoring patients physical health, monitoring patients in seclusion and after the use of rapid tranquilisation.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as **requires improvement** because:

- During our last inspection, not all areas of the ward were included in the ligature audits. Ligature audits did not indicate timescales when works were scheduled to be carried out. Patients' personal items posed potential ligature risks on the wards. During this inspection we found that a systematic approach to managing ligature risks had been introduced. However, on Avonmore some areas of the ward had not been included on the ligature audit. On Ravenscourt ward there were large standalone rubbish bins in showers, toilets and bathrooms which could be potential ligature anchor points. These items were included in the ligature risk audit but there was no specific mitigation or management plan.
- During our last inspection, there were blind spots on Kestrel and Lillie wards. During this inspection, our concerns about blind spots on Kestrel had not been addressed although work had taken place on other wards.
- During our last inspection of the service in June 2015, one seclusion room was poorly maintained. During this inspection, the seclusion room on Finch was poorly lit and showed considerable signs of wear. There were holes visible in the floor where a fitted bed had been removed. The toilet was dirty and stained, and there was a smell of urine. Other seclusion rooms were clean and well maintained.
- During the last inspection, staff transferred female patients at Lakeside to a seclusion room on a male ward. Since then a de-escalation room has opened on Lillie ward. At Hammersmith and Fulham and Lakeside male patients were still transferred between wards on different floors when they need seclusion which could compromise patients' privacy, dignity and safety.
- Finch ward was poorly maintained with ripped furniture in the games room, damaged walls, and broken furniture in the bedrooms. Locks to bedroom doors were broken. The glass panel on the door to the nurses' office had been broken for six months and was covered with an ill-fitting piece of plywood.
- Doctors providing medical cover out-of-hours were required to support a number of different wards and teams. Junior doctors said that this resulted in them being extremely busy at times.

Requires improvement



Summary of findings

There had been recent incidents where the on call doctor could not be contacted, although we were told this had been addressed. The workload of junior doctors providing on-call cover needs to be reviewed.

- At the last inspection, some risk assessments were not updated after incidents. At this inspection we also found a few risk assessments that were not updated after incidents. On Avonmore and Ravenscourt risks presented by physical illness and frailty were not included in the assessment.

However:

- During our last inspection, the position of CCTV cameras meant that parts of patients' bedrooms were visible on CCTV footage if the bedroom door was left open. During this inspection, the CCTV had been adjusted so it was less intrusive.
- During our last inspection, debriefings were not taking place after incidents and seclusion on one of the wards. During this inspection debriefings were taking place on all wards.
- During our last inspection medicines were not managed safely especially the management of controlled drugs. At this inspection all medicines were stored securely in locked cupboards within the locked clinic rooms. The prescription charts had patient identifiable data and allergy status completed for all patients. Additional training had been provided on the management of controlled drugs.
- During our last inspection, staff were not always recognising and reporting incidents. At this inspection there was a good reporting culture.
- During our last inspection the completion and recording of reviews for patients in seclusion was not taking place. At this inspection this was being done appropriately.
- During our last inspection patients did not always have a record of physical health checks after the use of rapid tranquilisation. At this inspection these records were in place.
- Staff adhered to infection control principles, including handwashing.
- Ward managers could request additional staff to be allocated. On Askew ward there were 44 shifts in September 2016 where the number of staff was above the established staffing level.
- Staffing rotas showed the same agency staff were used consistently. Agency staff who were not familiar with the ward received an induction. Agency staff took part in team meetings, debriefings of incidents, supervision and reflective practice.

Summary of findings

- Wards had sought to address restrictive practices and 'blanket' restrictions by appointing a member of the nursing staff to be a restrictive practice champion.

Are services effective?

We rated effective as **requires improvement** because:

- During our last inspection, care plans were inconsistent in terms of their content and their focus on recovery. We also found that care plans did not adequately reflect patients' views. Patients were not always involved in the development of their care plan. During this inspection, whilst everyone had a care plan and these were regularly reviewed and reflected the views of the patient further work was needed to ensure they were recovery focused.
- Staff were not all receiving regular supervision of a high quality. This was not monitored by ward managers. Some staff had not completed an appraisal.
- At the Lakeside recovery wards, staff did not consistently monitor patients' physical health when they were prescribed high doses of antipsychotic medication.
- Access to psychological therapies was limited.
- On Ravenscourt ward some national early warning score charts, used to monitor physical health, were not fully completed. One patient care record showed that staff had not escalated concerns about a patients' physical health when there had been deterioration in physical wellbeing.

However:

- During our last inspection, handovers and multi-disciplinary meetings on some wards were consultant led and did not consistently involve staff from all disciplines. During this inspection, there were no concerns about the quality of these meetings.
- During our last inspection, the service did not ensure patients' rights under the Mental Health Act were read, understood and repeated when required. During this inspection, patients were informed of their rights.
- During our last inspection, the use of the Mental Capacity Act to be inconsistent. During this inspection, new mandatory training had been introduced and some staff demonstrated a good understanding of the MCA and there were examples of where it was used well.
- During our last inspection, not all patients were having their physical health assessed. At this inspection comprehensive assessments of patients' physical and mental health were

Requires improvement



Summary of findings

completed on admission. The service had introduced the national early warning score to ensure staff were recording patients vital signs to identify physical health concerns. A new portal in the electronic patient record system had been set up to improve the quality of the recording.

- Specialist training was provided to staff on psychosocial and family interventions, physical health, rapid tranquilisation and tissue viability.

Are services caring?

We rated caring as **good** because:

- During our last inspection of the service in June 2015, patients did not have individual behaviour support plans. During this inspection, we found some examples on the PICU of behaviour support plans being used. These plans had been well received by staff and patients.
- Staff engaged with patients in a positive manner. Staff provided appropriate practical and emotional support in a respectful manner. We saw staff sensitively distract patients when they appeared to be becoming distressed.
- On most wards, staff were proactive and sought to positively engage with patients. This included engaging patients in general conversation and in specific activities.
- On admission, patients were shown around the ward and introduced to staff and patients. Patients at Lakeside received a well-design booklet called 'A guide to your stay'.
- Most patients we spoke with told us that they were involved in their care planning. Primarily this took place at weekly ward rounds.
- Families and carers were involved in the patients care and treatment. They were invited to ward rounds and reviews.

However:

- We received mixed feedback from patients about their experiences of being on the wards.
- Patients were not routinely involved in decisions relating to the development and running of the service.

Good



Are services responsive to people's needs?

We rated responsive as **inadequate** because:

Inadequate



Summary of findings

- During our last inspection of the service in June 2015, patients were sleeping on other wards as a result of bed pressures. During this inspection we found that this continued to take place and there had been 68 incidents of patients sleeping on other wards between 1 May and 31 October 2016.
- In the six months before the inspection, the discharge of 122 patients was delayed for non-clinical reasons. Delays were usually caused by patients requiring accommodation or the provision of social care. Discharge co-ordinators have now been employed on each of the sites to support improvements.
- Patients on Finch, Hope and Horizon wards all said that their ward could be noisy and unsettled. Staff on Hope and Horizon said that the long, thin layout of these wards was unsuitable for patient's needs and did not provide sufficient communal space.

However:

- During our last inspection of the service in June 2015, patients who are less mobile did not have access to a call bell. This meant they could not request staff help from their bedrooms. During this inspection, we found that bedrooms were fitted with call buttons. Each ward at Lakeside had some bedrooms designated for patients with mobility needs.
- Most patients said the food was of good quality and that there was a varied selection of food provided.
- Each ward had a programme of creative, therapeutic and recreational groups, as well as supporting patients to engage in physical activities.
- Staff were familiar with the process to follow if a patient wanted to make a complaint. Discussions with staff and evidence from patient records showed that minor issues were resolved quickly without the patient needing to use the formal complaints procedure.

Are services well-led?

We rated well led as **requires improvement** because:

- During our last inspection of the service in June 2015, we found governance processes across the wards were not working well. At this inspection audits and other basic checks on the wards had improved. Ward managers were completing and had access to a range of information. However, further work was needed as this information was located in different places and did not identify clear trends or when improvements were needed. For example ward managers did not have a dashboard

Requires improvement



Summary of findings

of essential information to monitor their service. They could not see trends in practice such as the use of physical interventions. They could not compare their performance easily with other similar wards.

However:

- During our last inspection of the service in June 2015, staff generally felt supported at a local level by their ward manager but some felt disconnected from the wider organisation and senior staff. During this inspection, we found staff morale to be improving. Staff were aware of how to raise concerns and said they were able to do so without fear of victimisation.
- Staff knew and agreed with the organisations values. Ward managers said the objectives for their ward reflected these values.
- Staff knew who senior managers were and said they have visited wards. Staff spoke positively about the local service managers and matrons and said they visited often.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by West London Mental Health Trust are part of the trust's local services clinical service unit.

Lakeside mental health unit had four acute wards for adults of working age. There were two assessment wards. Finch ward accommodated up to 16 male patients. Grosvenor ward accommodated up to 17 female patients. There were four bedrooms between Finch and Grosvenor that could be used flexibly to accommodate male or female patients. There were also two recovery wards. Kestrel ward, for male patients, had 19 beds. Kingfisher ward, for female patients, had 20 beds.

Hammersmith and Fulham mental health unit had three acute wards for adults of working age. Ravenscourt was

an assessment ward for male patients. Avonmore was a male recovery ward. Both wards had 22 beds. Lillie ward was a recovery ward with 16 beds for female patients. There was one PICU called Askew ward. The PICU had 12 beds and was for men only.

St Bernard's hospital had two acute wards for adults of working age. Horizon ward had 14 beds for male patients. Hope ward had 17 beds for female patients. These were both assessment wards.

We inspected the services provided by West London Mental Health Trust at St Bernard's and Ealing Community services twice between October 2012 and October 2013. All areas inspected were found compliant. Our last inspection of acute ward for adults of working age and PICU services was in June 2015.

Our inspection team

The team was comprised of an inspection manager, two inspectors, a clinical fellow, four specialist advisors and two experts by experience. The specialist advisors were a consultant psychiatrist, two nurses and a psychologist who had experience of working in acute services.

Why we carried out this inspection

When we last inspected this service in June 2015, we rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall;

We rated this core service as inadequate for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

Following the June 2015 inspection, we told the trust it must make the following actions to improve the acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that the use of rapid tranquilisation medication is clearly stated on patients' medication charts and that the necessary physical health checks take place and are recorded after this medication has been administered.
- The trust must ensure all fittings in the ward are included in ligature audits and where needed that works are completed. Ensure that on the psychiatric intensive care unit patients' personal items which may present a ligature risk to other patients are appropriately stored when not in use.
- The trust must ensure that medicines are managed and administered safely.

Summary of findings

- The trust must ensure that seclusion rooms are located so that they can be used safely and accurate records must be available when seclusion is used and of the checks done whilst the patient is in seclusion.
- The trust must ensure that staff clearly understand the incident reporting thresholds and report all incidents.
- The trust must ensure that patients have their physical health care needs assessed and ongoing checks where needed.
- The trust must ensure governance processes are working effectively to identify areas for improvement to support patient safety.

These related to the following regulations under the Health and Social Care Act (Regulated

Activities) Regulations 2014:

Regulation 9 Person Centred Care

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding service users from abuse and improper treatment

Regulation 17 Good governance

Regulation 18 Staffing

At this inspection we followed up the actions we asked the trust to make at the last inspection.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited all ten wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 44 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 49 other staff members; including doctors, nurses and social workers
- interviewed a service manager and a matron
- interviewed the head of acute services and clinical director with responsibility for these services
- attended and observed 11 hand-over meetings and three multi-disciplinary meetings.
- collected feedback from 67 patients using comment cards.
- looked at 45 treatment records of patients.
- carried out a specific check of the medication management on ten wards.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

On Avonmore, Ravenscourt and Askew wards, feedback from patients was generally positive. Overall, patients told us they felt safe and got on well with staff. They said there were sufficient staff on duty. Patients commented that staff were respectful, understood their needs and

involved them in care planning. However, a few patients, particularly on Avonmore ward, had a more negative view. These patients said they did not feel safe on the ward and found some staff unapproachable.

On Horizon, Hope and Lillie wards we received mostly positive feedback. Patients we spoke with said that staff were polite, respectful and generally made time for them and their requests. Patients also said they felt safe on the

Summary of findings

wards, although on Horizon patients said it could be unsettled. Despite the positive feedback, some patients we spoke with felt that staff would ignore them, could be rude and often seemed busy with administrative work. Patients also noted that whilst it didn't happen often, staff could occasionally cancel their escorted leave. Some patients also told us they did not receive copies of their care plan or that they disagreed with what was in the care plan.

Similarly at the Lakeside Unit, feedback was mixed. Patients on Kestrel ward were quite positive. They told us that the ward was clean and that the staff were very supportive. Patients on other wards said that the wards

were noisy and unsettled. Some patients said that their possessions were not safe. A number of patients recognised that staff were under pressure. They said that staff did their best in difficult circumstances.

We received 67 comment cards. In total, 29 of these were classified as positive, 18 were negative and 20 were mixed. There were some positive themes. Some comment cards stated that staff were hard working, staff listened to patients and that staff responded well to patients' needs. Other comments were that wards were noisy, busy and that one ward was unsafe and unhygienic. There were two concerns about staff using unreasonable force against patients.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that sufficient beds are available for patients on each ward and patients are not admitted to one ward and then sleep on another ward during their admission.
- The trust must ensure that at the Hammersmith and Fulham mental health unit and Lakeside seclusion rooms are located so they can be used safely and that patient transfer to seclusion facilities does not compromise the patient's privacy and dignity.
- The trust must ensure that the seclusion room on Finch ward is clean and well maintained.
- The trust must ensure that the new ligature management policy is fully applied and comprehensive ligature audits for each ward and clear actions when the need for further improvements are identified.
- The trust must address the risks presented by the blind spots on Kestrel ward.
- The trust must ensure that Lillie ward is clean and all the furniture and fittings are well maintained.
- The trust must review the junior doctors out of hour's rotas to ensure the workloads are safe.
- The trust must ensure patient risk assessments are updated following incidents.

- The trust must ensure that action is taken whenever high temperatures are recorded on refrigerators to ensure medication is in an appropriate state to use.
- The trust must ensure that supervision and appraisals are completed and fully recorded. Managers must be able to assess both the competency of all staff and appropriateness of the supervision provided.
- The trust must ensure that ward managers have sufficient clear and accurate information to monitor the quality of services being delivered.

Action the provider **SHOULD** take to improve

- The trust should continue to recruit permanent staff to reduce the use of temporary staff and further improve consistency of care.
- The trust should ensure clinical equipment is well maintained and calibrated where needed so it provides accurate readings.
- The trust should ensure that care plans for patients on recovery wards focus on recovery and support patients in developing the skills they will need when they are discharged.
- The trust should ensure that steps are taken to mitigate the risks associated with prescribing high dose anti-psychotic medication and patients' physical health is monitored.

Summary of findings

- The trust should ensure that patients have access to psychology services.
- The trust should ensure that staff completing national early warning score charts have sufficient skills and expertise to respond to deterioration in physical wellbeing.
- The trust should ensure that admissions to hospital are a positive experience for patients and that this is reflected in feedback. The trust should also involve patients in decisions about the development and running of the wards.
- The trust should ensure that staff avoid using medical jargon in care plans and treatment. The trust should ensure that staff speak to patients in a way patients can understand.
- The trust should aim to reduce the number of patients being placed outside their area during an admission.
- The trust should work with partners to continue to reduce the number of discharges that are delayed for non-clinical reasons.
- The trust should ensure that where needed, interpreters are arranged for individual patients.

West London Mental Health NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Acute wards at Lakeside Mental Health Unit	Lakeside Mental Health Unit and Hounslow community services
Acute wards at Hammersmith and Fulham Mental Health Unit	Hammersmith and Fulham Mental Health Unit and community services
Acute wards at St Bernard's Hospital	St Bernard's and Ealing community services

Mental Health Act responsibilities

Overall, staff showed a good understanding of the Mental Health Act 1983 (MHA), MHA Code of Practice and the guiding principles.

Training on Mental Health Law had been completed by 87% of staff.

Patients subject to the provisions of the MHA were given information about their rights.

There was a MHA Office at each site where original statutory documents were stored securely. MHA managers provided support to staff in making sure the Act was followed in relation to renewals, consent to treatment and appeals.

An independent mental health advocacy (IMHA) service was available to patients.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff showed a good understanding of the principles of the Mental Capacity Act, and how it would relate to practice on the wards. However, compliance with mandatory training on the MCA, which had only recently been introduced, was still low at just 59%.

Capacity to consent to admission and treatment was recorded when patients were admitted. Mental capacity was reviewed at ward rounds, and recorded in the progress notes.

Are services safe?

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

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

Our findings

Acute wards

Safe and clean environment

- Staff were unable to observe some parts of the wards due to restricted views from corridor corners and fire doors. Some bedrooms and seating areas were set back from the main corridors. On Ravenscourt ward, there were no mirrors to address blind spots. On Horizon Ward, staff highlighted that corridors were narrow and that it was difficult to see patients from the nurses' office. On Kestrel Ward, there was a long corridor that nurses could not see from the nurses' office that included two bedrooms that were secluded from the main corridor. In most cases, staff mitigated risks with convex mirrors and regular observation of areas that were out of direct view. Avonmore ward used CCTV. At the last inspection we were concerned that this faced patient bedrooms and compromised their privacy. At this inspection we found that the ward had repositioned the CCTV to ensure that it did not include parts of patients' bedrooms. At the last inspection we said the trust should address the blind spots of Kestrel and Lillie wards but this had not been done on Kestrel.
- At the last inspection we said that the trust must ensure that all fittings on the ward were included in the ligature audits and that where needed works were completed. Since this inspection the trust had completed a lot of work. This included the development of a ligature point assessment and management policy across the trust. Ward managers had all been trained to use the assessment tool. Assessments and action plans had been completed for each ward. These plans contained a ligature risk awareness record signed by all members of staff, a heat map of the ward with all areas coloured red, amber or green to indicate the level of risk, a copy of the ligature policy, list of identified ligature points and an action plan. In addition the trust has continued to assess, adapt and remove ligature anchor points across their acute wards. Staff allocated patients that were assessed as being at risk of self-harm to bedrooms near the nursing offices and provided enhanced observations. Staff completed general observations of all wards every 15 minutes. We recognised all the work that had taken place. However, we identified a few ligature points that were not included in the plans. For example, on Avonmore some areas of the ward had not been included on the ligature audit. On Ravenscourt ward there were large standalone rubbish bins in showers, toilets and bathrooms which could be a ligature anchor point. These items were included in the ligature risk audit but there was no specific mitigation or management plan. Some ward action plans included work that was overdue.
- All wards were single sex. At the Lakeside Unit, there was a corridor with four bedrooms between Finch, the male assessment ward, and Grosvenor, the female assessment ward. The corridor had doors that staff could use to divide the two wards. This meant that staff could adjust the capacity on each ward to accommodate varying numbers of male and female patients.
- Each ward had a clinic room that was clean and well equipped. The trust used green stickers to indicate when staff had cleaned equipment. Medicines and equipment were stored correctly and organised well, making it easy for nurses to access the items they needed quickly. At the last inspection we said the trust should ensure that medical equipment is properly maintained, repaired promptly and is accessible. The trust had introduced a policy and procedure, which included prompts to monitor this across the trust. At this inspection we found this had mostly been achieved. On Hope ward, the clinic room did not have an examination couch and the ECG machine was faulty. Staff had sent the machine for repair and staff told us they borrowed the machine from another ward or sent patients to the Accident and Emergency department at Ealing Hospital. Records showed there were gaps in the calibration of blood monitoring equipment on Horizon and Grosvenor.
- At the last inspection we said that seclusion rooms must be located so they can be used safely. Since this inspection the trust had created a new de-escalation facility on Lillie ward at the Hammersmith and Fulham unit. This meant the female patients no longer needed to go to a seclusion room on a male ward. Very occasionally when female patients required seclusion,

Are services safe?

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

staff transferred them from Hammersmith and Fulham mental health unit to Hope Ward at St. Bernard's hospital. This had occurred on two occasions in the six months from 1 May 2016 to 31 October 2016. At this inspection we found that each assessment ward at Lakeside and St. Bernard's had a seclusion room. These facilities were safe for staff and patients. Each seclusion room had a toilet and a clock. The rooms allowed for clear observation and two-way communication. On Hope and Horizon there were interactive screens for patients to view care plans and other documents whilst in seclusion. If patients on recovery wards at Lakeside required seclusion, staff placed them in a seclusion room on an assessment ward on another floor. Avonmore and Ravenscourt wards at Hammersmith and Fulham did not have a seclusion room. Staff placed male patients in the seclusion room on Askew ward. However, this meant that staff would need to transfer patients down a flight of stairs and through a communal dining room shared by all wards. This did not promote patients privacy and dignity and could have potential health and safety implications.

- At the last inspection we said the trust should ensure that seclusion rooms are clean and maintained regularly. This was mostly the case however, on Finch, the seclusion room had poor lighting and showed considerable signs of wear. There were holes visible in the floor where staff had removed a fitted bed. The toilet was dirty and stained, and there was a smell of urine. This room was also located on a corridor with other bedrooms. This led to complaints from other patients about high levels of noise when staff placed patients in seclusion and when secluded patients were particularly distressed.
- The quality of the ward environments varied. The dining rooms, bathrooms and bedrooms on Hope and Horizon were visibly clean and well maintained. We reviewed cleaning records that demonstrated regular cleaning of the wards. However, outside windows on Horizon ward were dirty and cleaners only cleaned windows from the inside. Finch ward had poor maintenance that included ripped furniture in the games room, damaged walls in bedrooms, and broken furniture in the bedrooms, such as chests of drawers with doors hanging off. Many locks to bedroom doors were broken. The glass panel on the door to the nurses' office had been broken for six months and staff had covered this with an ill-fitting

piece of plywood. Other wards at the Lakeside Unit were generally clean and well maintained. During our morning observation of Lillie ward there were areas that were dirty, had over filled bins and cobwebs on the wall. However, by the afternoon the ward was noticeably cleaner and patients did not comment on the ward being unclean. All ward areas on Avonmore and Ravenscourt, including lounges, kitchens, bathrooms and bedrooms, were visibly clean. Furnishings were in a good condition and were comfortable.

- Each ward had a patient led assessment of the care environment (PLACE). These assessments covered the condition, appearance, maintenance and cleanliness of the wards. The Lakeside Unit and the wards at Hammersmith and Fulham Mental Health Unit achieved scores of 97.9% and 98.1%. The score for wards at St. Bernard's Hospital was 91.9%. This was noticeably lower than both the trust average (92.5%) and the national average (97.9%)
- Staff adhered to infection control principles, including handwashing. Hand washing facilities were available in clinic rooms, bathrooms, shower rooms and toilets. Wards had mounted hand sanitiser gel by the entrance to each ward, along with guidance for all visitors to use this on entering and leaving the ward. Infection control audits provided evidence bed decontamination and hand washing.
- All wards had an environmental risk management plan. This included a floor plan showing a risk rating of red, amber or green for each area of the ward. These floor plans were displayed in the nurses' offices.
- On all the wards staff carried personal alarms. There were call buttons in most bedrooms and bathrooms. Emergency alarms were located in hallways. At Hammersmith and Fulham there had been recent incidents where junior doctors' had not been given personal alarms or these had not worked when activated. Staff had escalated this to senior management, who had addressed the issues when we visited the wards.

Safe staffing

- Both Horizon and Hope wards had recently changed the number of staff on each shift from five in the morning and afternoon and four at night to seven in the morning and afternoon shifts and six on night shifts. Staff

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highlighted this increase was due to the closure of Discovery ward but added that the increased establishment levels included one member of staff who would be allocated for security. On the assessment wards at Lakeside, Finch and Grosvenor, there were five staff on duty during the day and four at night. Two of these staff were nurses. On the recovery wards, Kestrel and Kingfisher, there were four staff during the day and three at night. As with the assessment wards, at least two members of staff were qualified nurses. The higher level of staffing on admission wards was to accommodate the assessments carried out on admission.

- The average vacancy rate for qualified nurses was 29%. The vacancy rates were particularly high at the Lakeside unit. Vacancy rates for qualified nurses was 59% on Grosvenor ward, 38% on Kingfisher and 35% on Finch. There were eight healthcare assistant (HCA) vacancies across all wards, although Grosvenor, Hope and Horizon had a surplus of seven HCAs in total.
- This high level of nursing vacancies meant that wards used bank and agency staff on a frequent basis. Data from 1 July to 30 September 2016 showed that wards used at least one bank or agency member of staff on most shifts. Grosvenor had the highest use of agency staff, filling 473 shifts during this period. Staff rotas demonstrated that wards regularly used the same agency staff, mitigating the risk that agency staff would be unfamiliar with the ward and its patients. Many bank staff were student nurses or retired nurses who were familiar with the environment. Ward managers and unit co-ordinators also supported staff in helping with extra shifts. Staff gave inductions to bank and agency staff who were not familiar with the ward and introduced them to patients. Ward managers at Lakeside told us that agency staff took part in team meetings, debriefing of incidents, supervision and reflective practice. An agency nurse we spoke with confirmed this. This demonstrated that wards integrated agency staff into the wider staffing activities on the wards. Records showed that agency staff took part in ward-based training such as training on fire safety, ECGs and NEWS charts. The staff and patients we spoke with did not raise concerns about the high use of agency staff.
- Ward managers could request the allocation of additional staff. This was authorised by the service manager. Ward managers allocated additional staff on a routine basis if more than one patient required one-to-one observations. Wards could also book extra staff if there were particularly challenging circumstances or a high level of acuity on the ward.
- The average level of sickness across all the acute wards was 2.4%. Sickness was highest on Grosvenor, Kestrel and Ravenscourt wards, which all had a rate of 4%. The average rate of sickness in the NHS in England is around 4%. Staff turnover rates were high, with a rate of 19% across all acute wards. The turnover rate was particularly high on Grosvenor, at 29%, Kingfisher, at 26% and Hope, at 24%.
- At the last inspection we said the trust should ensure that safe staffing levels are maintained when supporting patients in the health based place of safety. At this inspection we found that whilst wards maintained safe staffing levels, staff at Lakeside and Hammersmith and Fulham said they often felt stretched. Nurses on Finch and Grosvenor said it could be difficult to complete all the nursing duties for a shift when there were a high number of admissions. Staff on Kestrel also felt similarly stretched when there was a patient in the health based place of safety attached to the ward that needed support from two members of staff. However, staff across all the acute wards said they rarely cancelled escorted leave, one-to-one sessions and other activities because of a shortage of staff. Staff said there were sufficient staff to carry out physical interventions and that neighbouring wards provided additional staff if necessary.
- Junior doctors provided medical cover during the day. Duty junior doctors covered multiple sites out of hours including accident and emergency units, crisis teams, older peoples' teams, forensic and acute teams. Three doctors told us they struggled with covering such a large area and said there could be delays when patients needed assistance. A junior doctor at Lakeside said they were required to provide out-of-hours cover to five wards, a health based place of safety and the accident and emergency department at the hospital on the same site. At St Bernard's the out of hours doctor has to cover an even greater workload as all the forensic services are on this site. They told us that this resulted in them being extremely busy at times. The medical director had shadowed a junior doctor on-call shift at St Bernard's prior to the inspection but the large workload still

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needed to be addressed as there was a risk that the on-call junior doctor input would not be sufficient to respond to emergency situations. Prior to the inspection we heard from Health Education England who told us that at Hammersmith and Fulham, there had recently been incidents where the on call doctor did not have the on call bleep with them and where the handover had not taken place face to face but through mobile phone messages which was unacceptable. Staff had recently escalated concerns about accessing medical cover and the trust had addressed this. In addition to the bleep, an on call mobile number was also available to access on call medical cover. Junior doctors were now collecting the bleep and completing a handover at the start of the shift.

- On 31 October 2016, the rate of compliance with mandatory training for staff working on acute wards was 86%. The trust target was 90%. Compliance was lowest with recently introduced training on the Mental Capacity Act at 59%, raising awareness of radicalisation (WRAP) at 70%, and information governance at 74%. Managers we spoke with said it was difficult to book face-to-face training for training on the Mental Capacity Act and awareness of radicalisation. Whilst online learning was available, many staff preferred the face-to-face training.

Assessing and managing risks to patients and staff

- Between 1 May and 31 October 2016 there had been 109 incidents of seclusion on the acute wards. Finch ward had the highest number of incidents of seclusion, with 35. Grosvenor and Horizon followed with 20 and 17 respectively. On 10 occasions, staff had to transfer male patients from Kestrel a recovery ward to the seclusion room on Finch. There were no incidents of long-term segregation across all three sites.
- During this period, there had been 252 uses of restraint. The highest use of restraint was on Hope, with 52 incidents involving 19 patients, and Grosvenor, with 41 incidents involving 17 patients. These were both female assessment wards. On Finch there were 32 incidents requiring the use of involving 26 patients. The highest use of prone restraint was on female wards. On Hope, there were 27 incidents of prone restraint, on Kingfisher there were 17 and on Grosvenor there were 12. Staff told us that the use of prone restraint was limited to two circumstances. These were to administer intra-muscular medication safely whilst restraining the patient, or when enabling staff to withdraw safely from a seclusion room.
- At the last inspection we said the trust should ensure risk assessments are updated after an incident. At this inspection we found that wards completed risk assessments on a standard form and entered this onto the electronic patient record. Staff undertook a risk assessment of every patient on admission. On Finch and Kestrel at Lakeside, we found that staff had not updated risk assessments after separate incidents involving a patient who absconded and an incident with an aggressive patient requiring staff to call the police. On Avonmore at Hammersmith and Fulham, a record showed that staff had not updated the risk assessment after serious incidents, although staff had noted these incidents on the patient's electronic care record, and recorded it on an incident form. On Avonmore and Ravenscourt we found that risks presented by physical illness and frailty were not included in the risk assessment. On other wards, we noted that staff regularly updated and risk assessments.
- Wards had sought to address restrictive practices and 'blanket' restrictions by appointing a member of the nursing staff to be a restrictive practice champion. Ward managers gave examples of how they had reviewed and reduced restrictive practices. Patients were now able to have access to drinks and snacks throughout the day and night. There was no longer a fixed time for television in the patients' lounges. The trust had held restrictive practice conferences and all staff had received training in least restrictive practices. Informal patients could leave at will and no unlawful restrictions were in place.
- The service provided different levels of observation of each patient based on the patient's level of risk. Baseline observations took place every hour. Intermittent observations were every 15 minutes. Enhanced observations involved staff being with the patient, either within eyesight or at arms-length, at all times. Occasionally, staff placed patients presenting a particularly high risk on 2:1 observations. Nurses could authorise an increase in the level of observation. Staff, in consultation with the unit co-ordinator and a doctor made the decision to decrease the level of observation. Staff had a good understanding of this procedure.

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- Wards banned items such as alcohol, drugs, sharp objects, glass bottles, cigarette lighters, plastic bags and weapons. Staff searched all patients for these items on admission and when they returned from leave. Wards used a metal detector for these searches. Staff carried out searches of patients' rooms as part of routine environmental checks. If a patient did not give consent to a search, the staff would explain the reasons for this. If a patient continued to withhold their consent, wards placed them on an enhanced level of observation to mitigate any risk that the patient may have prohibited items. Staff said that if a patient detained under the Mental Health Act continued to withhold consent to a search, they could enforce the search in accordance with the provisions of the Mental Health Act Code of Practice. However, staff did this as a last resort.
- Staff were trained in de-escalation techniques that involved talking to the patient about their concerns, encouraging the patient to move to another area of the ward, offering medication if required or providing distractions. Staff consistently told us that they only used restraint when de-escalation had failed. Lillie ward had begun piloting a violence reduction programme as part of the trust's quality improvement plan.
- At the last inspection we said that the trust must ensure the use of rapid tranquilisation is clearly stated on the patients medication charts and that the necessary physical health checks take place and are recorded after this medication has been administered. At this inspection we reviewed four records relating to the use of rapid tranquilisation (RT). We observed that staff recorded the use of RT on patients' medication charts and carried out physical health checks after administering the injection. These checks were to mitigate the risk of adverse reactions that could result in significant harm to the patient. One patient on Avonmore ward had recently received RT. Staff had clearly recorded this in their notes. Staff undertook post dose observations and recorded this in their notes. We reviewed three records of RT on Finch. In each instance, staff had clearly documented the reason for the use of RT. This was consistent with the indication stated on the medicines administration record. There was no mention of post dose observations on one record. On the other two records we reviewed, staff had carried out physical checks a number of hours after the injection. In both cases, the record stated that the patient had been too distressed or disturbed to carry out physical checks. The patient had remained under one-to-one observations during this time.
- At the last inspection, we said the trust must ensure that accurate records are completed when a patient is in seclusion and that the necessary checks take place to ensure the patient is safe. The trust said that they had created a new portal on the electronic patient record system to help records to be completed when needed and monitored. We reviewed four seclusion records. All records demonstrated that staff recorded observations every 15 minutes, nursing reviews took place every two hours and reviews by a doctor took place every four hours. Staff were using the specific section of the electronic patient records for recording of seclusion.
- Staff had received training in safeguarding adults and children. Staff we spoke with were aware of the trusts safeguarding policies and procedures and were able to give examples of how they would respond to safeguarding concerns. Each ward had appointed a nurse as a safeguarding 'champion.' All the teams worked closely with the local authorities when there were safeguarding concerns raised. We case tracked a number of patients where there were current safeguarding concerns and found that these concerns had been appropriately identified, discussed, immediate safety plans put in place, and where appropriate a safeguarding alert raised.
- The multi-disciplinary teams (MDT) discussed requests by patients for children to visit. The MDT made a decision about whether this was in the best interests of the child. Each site had a designated room off the ward for children visiting.
- At the last inspection, we said the trust must ensure that medicines are managed and administered safely. This particularly related to the safe management of controlled drugs. On this inspection we found that medicines were stored securely in locked cupboards within locked clinic rooms. The prescription charts had patient identifiable data, and allergy status completed for all patients. A ward pharmacist attended the wards each weekday and was contactable for advice. Pharmacy technicians also attended the ward to stock up medicines. Controlled drugs (CD) audits on Grosvenor ward highlighted mistakes staff made in the

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CD register. In light of this, pharmacy staff had conducted training sessions to minimise future mistakes. Wards recorded fridge temperatures on a daily basis. On Kingfisher, we observed that fridge temperatures were over the recommended limit on six dates in November 2016. On Kestrel, the temperature was too high on nine occasions in October 2016. Neither ward had taken actions to address these high temperatures. This meant the medication stored in these fridges could be potentially unsafe.

Track record on safety

- In the 12 months from 1 November 2015 to 31 October 2016 there were 46 serious incidents that required investigation.
- The most frequent serious incident was a 'failure to obtain an appropriate bed for a child who needed it.' This happened on 15 occasions. Finch had the highest number of incidents, with 10 incidents taking place during this period. This included a serious fire set by a patient in a bedroom in June 2016.

Reporting incidents and learning from when things go wrong

- At the last inspection we said that the trust must ensure that staff clearly understand the incident reporting thresholds and report all incidents. The trust said that they had revised the incident reporting policy, held incident reporting roadshows across the trust to raise staff awareness and introduced a new electronic system to report incidents. At this inspection found this had all taken place. Managers were organising further training to improve staffs' knowledge of incident reporting. The staff we spoke with were aware of what constituted an incident and knew how to report it. Staff recorded incidents on a standard form. Incidents were reviewed by a central team. Ward managers said that they reviewed all incident reports. However, one ward manager said they were only able to access incident reports they had submitted themselves. Therefore, it was difficult for them to review reports comprehensively to ensure that all actions to address identified concerns were taking place.
- Incident reports we reviewed showed that staff were open and transparent after an incident had occurred. Staff received feedback on the outcome of investigations and learning. This could be through the

trusts intranet where they posted bulletins, or in team meetings where staff discussed and reviewed reports of serious incidents requiring investigation (SIRI) for learning appropriate to the individual core service.

- The trust had made improvements as result of learning from serious incidents. The provider had taken measures to improve staff awareness of potential ligature points that patients may use to self-harm. After the fire on Finch, the trust reviewed emergency evacuation plans, staff undertook training and plans were in place to change the locks on bedrooms doors. One serious incident involved the management of a patient's diabetes. Following this incident staff had received diabetes awareness training and the trust had introduced national early warning scores for physical health. The trust had appointed a clinical nurse consultant to lead improvements in physical health care.
- Staff shared learning from incidents in fortnightly reflective practice sessions. A psychologist facilitated the groups. Staff spoke positively about sessions.
- At the last inspection, we said that staff and patients should be debriefed after incidents. At this inspection we found that after serious incidents, debriefing sessions took place and the trust offered staff support. The trust offered further support or counselling if this was required. A violent incident involving family members had taken place on one of the wards. Service directors attended the ward within 30 minutes to support the debriefing with staff. Some of the nursing staff were off sick as a result of the incident. These staff members received support from psychologists. However, a junior doctor told us a patient had assaulted them. They said there had been no debriefing, despite them feeling very shaken by the incident. They also said they received no feedback from the incident report.

Psychiatric intensive care unit (PICU)

Safe clean environment

- There were some blind spots on Askew ward. Staff mitigated the risks the blind spots presented by the use of CCTV. CCTV images were visible in the nurses' station.
- On Askew ward, some ligature anchor points were not included in the ligature risk audit. For example, the knob used to adjust the viewing panel on bedroom doors. Staff had not updated the ligature risk audit when the

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maintenance department had completed some minor works, for example the filling of gaps between towel holders and soap dispensers. Some descriptions in the ligature risk audit were vague, for example 'ceilings' in patient bedrooms. This description was too vague to appropriately alert staff to the potential ligature anchor points and their potential risk level.

- The clinic room was appropriately equipped. An emergency grab bag was available. Staff regularly checked this bag. The contents were all in date.
- The seclusion room on Askew ward was compliant with standards in the Mental Health Act Code of Practice. Staff and the patient could communicate through an intercom system. There was a mattress, pillow and covering. There were no apparent safety hazards. There were reinforced windows that provided natural light. Staff controlled lighting externally. This provided a main light and subdued lighting during the night. The doors opened outwards. Heating and air conditioning were externally controlled. This enabled staff observing the patient to monitor and adjust the room temperature. There were no blind spots. A clock was visible to the patient from within the room. Patients had access to toilet and washing facilities.
- All ward areas including lounges, kitchens, bathrooms and bedrooms were visibly clean and well maintained. Furnishings were in a good condition and were comfortable. The service carried out patient led assessments of the care environment (PLACE). Askew was part of the Hammersmith and Fulham Mental Health Unit. This unit had achieved an overall score of 98.1%. This was above the trust average of 92.5% and the national average of 97.9%.
- Staff adhered to infection control principles, including handwashing. Hand washing facilities were available in clinic rooms, bathrooms, shower rooms and toilets. Staff had prominently mounted hand sanitiser gel by the entrance to the ward, along with guidance for all visitors to use this on entering and leaving. Cleaning records were up to date and demonstrated that domestic staff cleaned the environment regularly. Regular mattress checks and legionella checks were completed.

- The clinic room contained suitable equipment including scales, height stick, ECG machine, blood pressure monitor and blood testing kits. These were visibly clean and had been maintained regularly and, where required, calibrated.
- When staff identified patients as having higher support needs they allocated bedrooms closer to the nurses' station. Staff carried personal alarm systems. There had been recent incidents of alarms used by junior doctors not working when activated. The doctors had escalated this to senior management. The manager said this matter had been resolved.

Safe staffing

- Overall, staffing levels were safe. The establishment for each shift was clear and the trust monitored compliance with this. A small number of shifts for October wards had not met their staffing complement. Rotas showed that the ward increased its staffing complement when needed. Staff rarely cancelled patient activities and escorted leave due to staffing shortages. A staff recruitment programme was ongoing. Patients said they thought sufficient staff were available on the ward. The majority of patients felt safe on the ward.
- During September 2016, the vacancy rate for nurses and HCAs was 13%. In September 2016, there were seven shifts where did not achieve its full complement. There were 44 shifts where the number of staff exceeded the full complement. Between 1 September 2015 and 30 September 2016 Askew ward had a staff sickness rate of 5%. This was higher than the average sickness rate of 2.4% on the acute wards.
- The trust had estimated the number and grade of staff required for all shifts. The ward manager was aware of this. The ward manager and the service manager had oversight of current vacancies for their ward. There had been a recruitment programme to fill vacant posts. There were two vacancies for nurses and three vacancies for HCAs. The ward aimed to have regular bank and agency staff to ensure consistency of care. This was not always possible. If bank or agency staff were unfamiliar with the ward, the ward manager provided an induction. This included orientating them to the physical environment and updating them on patient's presentation. The high number of shifts where

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staffing was above the established complement indicated advance planning to roster additional staff on duty where needed. There was a qualified nurse present in communal areas at all times.

- Each patient had a named nurse and the expectation was that patients would meet with their named nurse at least once each week. Staff did not raise any concerns with us about the number of staff available to carry out physical interventions safely.
- Arrangements were in place to ensure that adequate medical cover was in place night and day. Staff did not raise concerns about accessing medical cover.
- As at 31 October 2016, the training compliance for this core service was 86% against the trust target of 90%. On Askew ward, the manager had been in post for three months. They noted that on their arrival, training compliance rates had not been good and they had been following this up with staff in one to one supervision to ensure staff were promptly booked onto mandatory training courses.

Assessing and managing risk to patients

- There had been 14 incidents of seclusion in the six months from 1 May to 31 October.
- During this same period, there had been 32 incidents of restraint involving 12 patients. There had been nine incidents of prone restraint, one of which resulted in rapid tranquilisation. The service had sought to reduce the use of restraint. The service had introduced behaviour support plans. This included a focus on developing staff use of de-escalation techniques.
- For each patient staff had completed a risk assessment on admission. Risk assessments had been reviewed and updated regularly and after any incident had occurred. The trust used an electronic records system with a standardised risk assessment form. Staff could copy entries in progress notes directly into the risk assessment. A risk summary was also available in the electronic records system. This included details of recent risk incidents.
- Some blanket restrictions were in place. These were proportionate to the needs of patients requiring intensive support. For example, these restrictions prohibited patients from having cigarette lighters and telephone charging cables were kept in the nurses' office. Patients understood the reason for these

restrictions and agreed to them. The service had appointed a nurse consultant for restrictive practise. This nurse had undertaken training with staff to raise awareness regarding the use of restrictive practise.

- Admission criteria stated that the ward only accepted patients detained under the Mental Health Act (MHA). Staff were aware of trust policy and procedure regarding searches and observations. Patients did not raise concerns with us about searches or observations.
- One patient had recently received rapid tranquilisation. Staff had carried out post dose observations and recorded these observations in the patient's notes.
- The trust had developed a policy and procedure regarding seclusion that was in line with the Mental Health Act Code of Practice. We examined the care and treatment records for four patients who staff had recently placed in seclusion. These showed that for each patient, each period of seclusion had been appropriately authorised by a person who had reviewed the patient immediately prior to the episode of seclusion commencing. The start time of the episode of seclusion was clearly recorded, along with regular observations (at least every 15 mins) and medical, nursing and MDT reviews. An appropriately skilled and experienced member of staff observed the patient throughout the period of seclusion. Staff recorded the reasons for the need to continue seclusion. Where periods of seclusion were no longer required, staff promptly allowed the patient to return to the ward. Comprehensive records detailing all aspects of the period of seclusion were completed and were readily accessible.
- Safeguarding training was mandatory. Staff we spoke with were aware of the trusts safeguarding policies and procedures and were able to give examples of how they would respond to safeguarding concerns.
- The multi-disciplinary teams (MDT) discussed requests by patients for children to visit. The MDT made a decision about whether this was in the best interests of the child. Where child visits did occur, these happened in a designated child visiting room off the ward.
- Medicines were stored securely in locked cupboards within the locked clinic rooms. Staff had access to appropriate controlled drugs (CD) cupboards and registers. Medicines requiring refrigeration were not always stored at the required temperatures to remain

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effective. Staff recorded minimum, current and maximum fridge temperatures daily. Some temperatures were out of range and ward staff had not sought advice on this. Staff recorded the ambient room temperature of the room where medicines were stored. This meant that there was assurance that medicines stored at room temperature were effective. A ward pharmacist attended the ward daily and was contactable for advice. Pharmacy technicians also attended the ward to stock up medicines. Staff could access medicines out of hours and could contact an on call pharmacist.

Track record on safety

- No serious incidents had occurred between 1 April 2015 and 31 March 2016.

Reporting incidents and learning from when things go wrong

- Staff knew what constituted an incident and how to report it. The manager reviewed the incident reports to identify any themes, issues or other incident reporting trends. We did not identify any incidents that staff had not reported.
- Incident report showed that staff were open and transparent after an incident had occurred.
- We found evidence that the service had made improvements because of learning from serious incidents that had occurred. One serious incident had involved the management of a patient's diabetes. As a result of learning from this incident staff had received diabetes awareness training and a NEWS monitoring system for physical health had been introduced.
- Staff received feedback on the outcome of investigations and learning. This could be through the trust's intranet or in team meetings where staff discussed serious incidents requiring investigation (SIRI) reports.

Are services effective?

Requires improvement 

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Our findings

Acute wards

Assessment of needs and planning of care

- On admission, staff carried out assessments of patients' mental health, physical health and mental capacity to consent to admission and treatment. Staff also completed a risk assessment.
- At the last inspection we found that patients needed to have their physical health assessed and ongoing checks where needed. At this inspection we found that patients received a comprehensive physical health assessment on admission. The trust had introduced the national early warning score (NEWS) to ensure staff were recording patients vital signs to identify physical health concerns. The service had employed a nurse consultant to lead improvements in physical care. Staff had a target of 72 hours to complete a physical health examination. Records showed that staff achieved this target on most occasions. Most records showed that staff monitored and treated patients for complex physical health needs when necessary.
- At the last inspection, we found that the trust needed to ensure that care plans were more consistent in terms of their content, recovery focus, reflection of patients views and that patients were offered a copy of their care plan. At this inspection we found that all care plans were up to date, specific to the personal needs of patients and contained the patient's views on care and treatment. Some recovery plans clearly identified the patient's strengths, aspirations and support available to facilitate the patient's recovery. Other recovery plans were brief. For example, one recovery plan stated that the patient should work towards their recovery goals without stating what these were.
- All information was stored on an electronic patient record. Staff had individual 'log-in' names and passwords. The trust had introduced specific 'portals' on the patient's record to record physical health checks, seclusion records and mental capacity assessments. Staff did not use these portals consistently. For example, some patients had physical health observations recorded in their progress notes and others had these recorded in the specific portal. This could be confusing and make it difficult for staff to locate critical information quickly.

Best practice in treatment and care

- NICE guidance was not being adhered to when high dose antipsychotic prescribing took place. Staff placed stickers on prescription charts to identify patients on high doses of antipsychotic medicines. At Hammersmith and Fulham, staff monitored the risks presented by using high doses of antipsychotics through routine blood tests. However, at the Lakeside recovery wards there were three patients receiving antipsychotic medication above the limits recommended in the British National Formulary (BNF). This was often due to doctors prescribing medicines for patients to take if required, on top of the patient's regular medicines. We found that physical health checks including routine blood investigations were not carried out when medication was prescribed over the BNF limits. We discussed this with a nurse who was unaware of the need for additional physical health checks and the risks associated with high dose prescribing of antipsychotics.
- Access to psychological therapies was limited. At Hammersmith and Fulham, one psychologist who worked four days a week provided cover to five wards and the crisis team. At Lakeside, there was one psychologist covering four wards. This meant that the wards were not able to offer individual or group psychology to patients routinely.
- All three sites were located next to large general hospitals. This meant patients had access to physical health specialists when needed. Staff and patients gave examples of how specialist nurses and doctors provided treatment for diabetes and kidney disease. Consultant nurses for physical health supported staff with dressing wounds and infection control in these procedures.
- The service had adopted the National Early Warning Score (NEWS) as a system for tracking patients' physical health alerting the clinical team to any medical deterioration and triggering a timely clinical response. Staff had received training on this system. However, on Ravenscourt, we found the NEWS scores were not completed and recorded consistently in the same place on patient records. This meant that the information was not readily accessible and staff could not easily track any deterioration. We also found that staff did not take any action after health checks showed a patient had low

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oxygen saturation level of 79%. This would normally necessitate a referral to emergency services. This incident demonstrated that some staff did not have the appropriate skills to assess and monitor physical health.

- Staff monitored food and fluid intake for patients who had lost weight, had a low body mass index or when blood tests indicated concerns about the patient's physical health.
- All the wards used the Health of the Nation Outcome Scales (HoNOS) to assess and record severity and outcomes.
- Staff actively participated in clinical audit. These included audits of NEWS charts, care plans, controlled drug procedures, risk assessments and methicillin-resistant staphylococcus aureus (MRSA) prevention. During our visit, we saw that staff engaged in other clinical audits including safer staffing, patient care and treatment records.

Skilled staff to deliver care

- Multidisciplinary teams included psychiatrists, junior doctors, nurses, healthcare assistants, occupational therapists, pharmacists and activity co-ordinators.
- Staff were experienced and qualified. Some unqualified staff had completed a band four assistant practitioner training scheme. The service manager at Hammersmith and Fulham told us they planned to promote some HCAs who had completed the assistant practitioner training.
- New employees completed a corporate induction followed by a local comprehensive two-week induction programme. This included an introduction to the trust's policies and procedures and extensive work on preventing violence and managing aggression. When new staff arrived on the ward, they were supernumerary for their first week to allow them time to shadow experienced members of staff and become familiar with the ward. Newly qualified nurses met for a study day once a month.
- Monitoring of clinical supervision was inconsistent. Ward managers were not checking the frequency and quality of the supervision completed for their team. The supervision records we reviewed were not comprehensive. They did not document or address issues staff experienced on the ward or monitor the

employee's professional development. Records of the dates on which supervision had taken place showed these sessions were sporadic. In September 2016, supervision levels were 71% on Horizon ward, 67% on Lillie ward and 59% on Hope ward. Appraisal rates were also low with only 51% of permanent nursing staff receiving an appraisal across the acute in-patient wards. The appraisal rate was highest on Ravenscourt with 100% compliance. There was very low compliance on Kestrel and Finch, with just 5% of staff receiving an appraisal. Ward managers suggested that low appraisal rates were due to a high turnover of staff, resulting in there being few staff who had been working on the wards for a full 12 months. For example, on Grosvenor there was a high turnover of 31% and low levels of appraisals at 20%. However, this correlation was not borne out on other wards. Finch had a turnover rate of just 9%, but appraisals were very low at 5%.

- All the wards held regular multi-disciplinary team (MDT) meetings which staff were encouraged to attend.
- Specialist training was available, including training in psychosocial and family interventions, physical health and rapid tranquilisation and tissue viability. HCAs had completed assistant practitioner courses. Ward managers were receiving mentorship to support them in their leadership role. Staff spoke positively about these training opportunities.
- Systems were in place to address poor staff performance. On one ward, managers had suspended two staff from clinical duties in response to concerns raised by patients, whilst managers investigated the allegations.

Multidisciplinary and inter-agency team work

- At the last inspection, we found that the trust needed to review handover and multi-disciplinary meetings across the trust to ensure consistently high standards. The trust introduced standards for MDT meetings. At this inspection, we found that handovers for nursing staff took place at the end of each shift. Multi-disciplinary team handovers took place each morning. Ward rounds included input from all disciplines. The meetings we observed were an appropriate standard. Staff also met for team meetings on a fortnightly basis. Staff attended

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reflective practice sessions. The ward manager at Lillie ward had adopted the safety huddle as a method of catching up with teams on issues that could affect their safety.

- Wards worked closely with home treatment teams, recovery houses and community teams. Staff said there had been some difficulties in arranging support for patients who were returning to the community. Community teams did not accept referrals straight away if community mental health nurses had high caseloads.
- Wards had a police liaison officer who offered training in communicating with police and helped reduce patients going absent without leave. Staff also felt GPs were quick to respond to their request in regards to medication and physical health. Staff referred patients to specialist drug and alcohol teams if necessary. However, there was no ongoing contact with substance misuse services to help address substance misuse problems on the wards. Staff on Avonmore and Ravenscourt had not involved the police in addressing concerns about illicit drug use.

Adherence to the Mental Health Act (MHA) and MHA Code of Practice

- Eighty-seven percent of staff had completed mandatory updates on Mental Health Law. Staff demonstrated a good understanding of the MHA, the code of practice and guiding principles.
- Certificates confirming each detained patient's consent to treatment, or certificate from a second opinion appointed doctor (SOAD) were completed and attached to prescription charts.
- Staff gave patients information about their rights under the MHA on admission. This was recorded either in a designated area in the electronic patient record or in the progress notes. We saw that staff had given a patient information in their community language.
- Staff had access to a MHA office at each site. MHA managers audited documentation to ensure it was up to date and appropriately completed. Staff were able to access support in making sure they followed Act in relation to renewals, consent to treatment and appeals.
- Doctors and approved mental health professionals had completed the statutory documents we reviewed correctly. Original paperwork was stored in the MHA office on each site. The MHA administrator uploaded all statutory documents to the electronic patient record.

- Staff conducted a MHA audit that included the patients' legal status and expiry dates, the dates on which rights were read and understood, the dates on which rights were repeated and if statutory documentation was uploaded to the electronic documentation system.
- Staff clearly displayed information about independent mental health advocacy (IMHA) services on notice boards. Staff we spoke with knew how to access advocacy services. In addition, advocacy services visited each ward on a weekly basis to speak with patients more generally. Patients we spoke with were aware of advocacy services and some patients had accessed support from them.

Good practice in applying the Mental Capacity Act (MCA)

- Compliance with mandatory training on the MCA was low at just 59%, although this training had only recently been introduced. Previously MCA training had been part of a mandatory Mental Health Law training course. Managers said whilst the training was available through e-learning the majority of staff preferred to complete the training face to face. There had been difficulties in booking staff on these courses.
- There were no deprivation of liberty safeguards (DoLS) applications for this core service between 1 January 2016 and 30 June 2016.
- During our interviews, staff showed a good understanding of the principles of the Mental Capacity Act and how it related to practice on the wards. For example, one patient had refused to wash and was experiencing severe self-neglect. The staff assessed the patient's capacity and concluded that the patient did not have capacity to make the decision about washing. Staff discussed the matter with the patient's family and held a multidisciplinary meeting to agree a course of action that would be in the patient's best interests.

Psychiatric intensive care unit (PICU) Assessment of needs and planning of care

- The three care records we reviewed showed that staff had comprehensively assessed patients on admission. This included a physical examination. Assessments by staff identified one patient as having a minor recurrent physical health problem. Doctors regularly monitored this patient's condition and provided treatment.

Are services effective?

Requires improvement 

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.

- Records contained up to date care plans. These were personalised and contained patient views. However, one care plan we looked at was not holistic or recovery orientated. For example, staff writing the care plan had not addressed the patient's social care needs. The patient's single recovery goal was to "return to live in Bangladesh". Staff had written more information on the patient in the progress notes but this was not included in the care plan.
- An electronic patient record system was used in the trust. This meant that inpatient and community services could access individual patient records. Staff were familiar with this system.

Best practice in treatment and care

- Stickers were used on some prescription charts for patients receiving high dose antipsychotic therapy (HDAT). Some patients on HDAT had received the relevant blood tests required. The trust was still in the process of implementing the new online system for tracking this information.
- Access to psychological therapies was limited. One psychologist who worked four days a week provided cover to five wards and the crisis team. This meant that the ward was not able to offer individual or group psychology to patients routinely.
- The trust had focussed on improving physical health care at Hammersmith and Fulham. The service had appointed a nurse consultant to lead on physical healthcare issues. The service had introduced the NEWS (national early warning score) system at Hammersmith and Fulham, and 92% of staff had received training on this.
- Staff used health of the nation outcome scores (HONOS) to measure patient outcomes.

Skilled staff to deliver care

- The multidisciplinary staff team included consultant psychiatrists, SPR doctors, other junior doctors, nurses, health care assistants and occupational therapists.
- Staff were suitably experienced and qualified. Some unqualified staff had completed a band four assistant practitioner training course.

- New staff received a corporate induction and a local induction to the ward. Bank and agency staff who were unfamiliar with the ward received a brief induction to the ward during their first shift.
- Trust data indicated that the supervision compliance rate on this ward was 49%. However, the ward manager was able to show us figures that indicated that the compliance rate for October 2016 on this ward was 96.15%. Although the ward manager was not able to bring up data for September 2016, they stated that the supervision compliance rate for that month had exceeded the trust target of 90%.
- Appraisal compliance rates on this ward were 92.6% that was higher than the trust target of 90%.
- The ward held regular MDT meetings which were attended by staff.
- Effective systems were in place to address poor performance.

Multi-disciplinary and inter-agency team work

- Staff held ward rounds were every week. The consultant arranged monthly clinical improvement meetings to develop clinical practice within the team.
- Nursing handover meetings took place at the start of each shift. Staff used a standard format to plan for this meeting, which highlighted tasks for staff to complete for each patient. We observed a lunchtime handover meeting and noted that staff discussed each patient individually and thoroughly. During their discussions, staff demonstrated knowledge and understanding of individual patient needs.
- The ward liaised with care co-ordinators and community mental health teams who were also involved in the care and treatment of patients. Where care co-ordinators were based within Hammersmith and Fulham they regularly attended ward reviews and care programme approach meetings. However, when patients lived in other boroughs covered by the trust, care co-ordinators often did not attend ward reviews. As Askew ward was the only PICU within the trust, patients could come from all three boroughs covered by the trust.

Adherence to the MHA and MHA code of practice

- A competent member of staff examined section papers when patients were admitted.

Are services effective?

Requires improvement 

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.

- Staff knew who their MHA administrators were, and were able to access them to gain support in making sure the Act was followed in relation to renewals, consent to treatment and appeals.
- Each ward kept clear records of the patients leave. When considering granting leave to detained patients, the responsible clinician reviewed potential risks and put in place contingency measures.
- Eighty-three percent of staff had completed mandatory training on the MHA.
- Staff we spoke with demonstrated a good understanding of the MHA, the Code of Practice and its guiding principles.
- Certificates confirming each detained patient's consent to treatment, or certificate from a second opinion appointed doctor were completed and attached to prescription charts.
- Information on patient's rights was available on each of the wards. Overall, we found that the majority of patients had their rights explained to them upon admission and at regular intervals thereafter.
- Staff clearly displayed information about independent mental health advocacy (IMHA) services on notice boards. Staff we spoke with knew how to access advocacy services. In addition, advocacy services visited each ward on a weekly basis to speak with patients more generally. Patients we spoke with were aware of advocacy services and some patients had accessed support from them.

Good practice in applying the MCA

- Compliance with mandatory MCA training was 69% although this was a recently introduced training course. Some staff showed a good understanding of the MCA.

Are services caring?

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

Our findings

Acute wards

Kindness, dignity, respect and support

- Throughout the inspection, we saw staff engaging with patients in a positive manner. Staff provided appropriate practical and emotional support in a respectful way. On Grosvenor ward, we noted that patients tended to initiate, instead of staff being proactive in providing support. On Ravenscourt ward, we saw staff sensitively distract patients when they appeared to be becoming distressed. This helped to de-escalate the situation. During the inspection, there was a calm atmosphere across all the wards.
 - Patients' feedback about their experiences of being on the wards was mixed. Some patients we spoke with felt that staff were interfering and often invaded their privacy whilst others had praise for the staff and found them approachable and supportive. Patients on assessment wards, such as Horizon and Finch, said the wards were unsettled and that it was often too noisy. Patients also recognised that staff were often very busy. For example, there were a number of comments that staff do their best in difficult situations. Patients on one ward spoke positively about the appointment of a new ward manager. They felt there had been positive change since the new manager had been in post.
 - During our conversations with staff and observations of ward rounds and handovers, staff showed they were familiar with patients and had a good understanding of their needs.
 - The trust carried out patient led assessments of the caring environment (PLACE). Within this assessment, the overall score for privacy, dignity and well-being across the three sites was 85.1%. This is higher than the trust's overall score of 80.15%, but lower than national average which is 89.7%.
- Patients also received an information pack on Ravenscourt. Patients on other wards did not receive any written information. Some patients on Avonmore commented that they did not receive sufficient information on admission to help orientate them to the ward.
- Most patients we spoke with told us that they were involved in their care planning. Primarily this took place through weekly ward rounds. Most patients said that staff had offered them a copy of their care plan. Some patients said they received regular one to ones with their named nurse.
 - All wards had weekly community meetings attended by staff and patients. These meetings gave patients the opportunity to feed back issues of concern and interest. Staff and patients attended a 'plan the day' at the start of each day. This meeting involved decisions about the times of escorted leave and arranging other activities. On most wards, staff used a 'you said, we did' board displayed in communal areas to show how issues raised in community meetings and complaints had been addressed. In Hammersmith and Fulham, Mind facilitated a patients' forum on each ward every month. Mind fed back any issues or concerns raised during the meeting directly with the ward manager for follow up.
 - Staff displayed information about advocacy services on all the wards. Advocates visited wards each week and were available to meet with any patient. The majority of patients were aware of advocacy services. Some patients who had used advocacy services spoke positively of their experience.
 - Families and carers were involved in patients' care and treatment. The multidisciplinary team invited families and carers to ward rounds and reviews. Patients on Ravenscourt ward particularly told us that they were happy with how their families and carers had been involved in decisions about their care and treatment. Some wards at Lakeside had notice boards displaying information specifically for families and carers.
 - Patients were not involved in decisions relating to the development and running of the service. For example, patients were not involved in staff recruitment.

The involvement of people in the care they receive

- On admission, nurses showed new patients around the ward and introduced them to staff and patients. Patients at Lakeside received a well-design booklet called 'A guide to your stay'. This contained information about care and treatment, ward routines, different professional roles, meal times and visiting times.

Psychiatric intensive care unit (PICU) Kindness, dignity, respect and support

Are services caring?

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

- Staff on Askew ward were proactive and sought to engage positively with patients. This included engaging patients in general conversation and in specific activities such as table tennis. We observed many proactive, positive one to one interactions between staff and patients.
- The majority of patients on Askew ward were positive about the care and treatment they received. Some said that staff were approachable. One patient commented that everybody there was very nice and that staff check how patients are. Patients said that the staff sit with patients and talk to them.
- Our observations of ward rounds and handover meetings showed that staff were familiar with patients and understood their needs.

The involvement of people in the care they receive

- The majority of patients on Askew ward told us that they had received sufficient information on admission to orientate them to the ward. Patients also told us they felt confident asking staff if they were unsure about anything.
- Some patients had participated in the development of their care plans and staff had given them a copy of this. Staff held ward reviews each week on this ward and patients told us that they attended ward reviews regularly. Patients said they were able to participate in discussions about their care and treatment. During our last inspection of the service in June 2015, we found that patients did not have individual behaviour support plans. During this inspection, we found some examples of individual behaviour support plans being used. These plans had been well received by staff and patients.
- Some patients told us that staff used clinical jargon and that they did not always understand what staff meant. For example, one patient said there had been a discussion around him being elated. He had not understood what this meant and had not felt confident to say this.
- Staff displayed information about advocacy services on the ward. Advocates visited the ward each week and were available to meet with any patients who wanted to speak with them. The majority of patients were aware of advocacy services. Some patients who had used advocacy services spoke positively of their experience.
- Families and carers were involved in patients care and treatment. Staff invited families and carers to ward rounds and reviews.
- Staff and patients held weekly community meetings. Patients could raise any issues or concerns in these meetings.

Are services responsive to people's needs?

Inadequate 

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

Our findings

Acute wards

Access and discharge

- Average bed occupancy across all the acute wards, between 1 January 2016 and 30 June 2016 was 94%. Within these figures, Grosvenor had the highest occupancy rate at 109% and Finch had the lowest at 72%. However, during our inspection, occupancy on Finch was 100%. Ward managers told us that all the wards were usually full.
- Between 1 January 2016 and 30 June, the service placed 30 patients in other hospitals outside the local area. The trust provided an example of patients placed out of the area on 28 August 2016. This showed there were 14 out of area placements, four of which were female PICU, four female acute and six male acute. The trust stated that the clinical director and local services senior management team closely monitored the use of the private providers. Multidisciplinary teams reviewed patients placed out of the area weekly.
- Patients from the three boroughs could use any of the beds on acute wards provided by the trust. The trust tried to admit patients to the hospital ward within the borough where they lived, but when this was not possible, they were placed at another of the sites. On the day of our inspection, 50% of patients on Avonmore in Hammersmith and Fulham were residents from Ealing. Staff said that when patients were admitted from outside the borough where the hospital was located, it could be more difficult for staff from the community mental health team to attend discharge planning meetings.
- Most ward managers said that when patients were on overnight leave, it was unusual for them to return to hospital. Patients were usually discharged from the ward if the period of trial leave had gone well. They said that as a result, they did not retain a bed for patients who were on overnight leave. However, we found an example of a patient who returned from leave late at night. Staff had planned for the patient to spend the night on a rehabilitation ward. The patient did not want to be on a different ward and slept in a chair overnight.
- At the last inspection we said that the trust should limit patients sleeping on wards as a result of bed pressures.

At this inspection we found that patients on Horizon ward were frequently required to sleep on the rehabilitation ward due to a high demand for beds. This had happened on more than 60 occasions in the six months before the inspection. Patients who stayed on Horizon but slept on a different ward did not have a room or any private space to use during the day. This disrupted the patients' continuity of care and also presented potential risks for the patient who slept on another ward and the patients and staff on the rehabilitation ward. The trust said that they mitigated this risk by assessing patients for suitability and risk prior to the sleepover.

- This trust did not have a psychiatric intensive care unit (PICU) for female patients. Female patients requiring intensive care were transferred to hospitals outside the area, usually in other parts of London. Between 1 May 2016 and 31 October 2016, nine women had been placed in PICUs provided by non-NHS organisations. At times, transfers to female PICUs were delayed because of a lack of beds being available. One patient on Grosvenor ward was in seclusion for eight days, with only two four-hour breaks from the seclusion room, whilst waiting for a PICU bed to become available. The occupancy rate for Askew, the Male PICU, was 93%. Four male patients had been on PICUs at other hospitals between 1 May and 31 October 2016.
- During this period, the discharge of 122 patients was delayed for non-clinical reasons. Delayed discharges occurred for a number of reasons such as waiting for the provision of appropriate social care or housing in the community, or delays in moves to other inpatient services. For example, two patients on Horizon ward were waiting to move to a low secure forensic service. The trust had recently introduced the role of discharge co-ordinator. This role focussed specifically on facilitating the discharge of patients who remained on the ward for non-clinical reasons.

Facilities promote recovery, comfort and dignity and confidentiality

- Patients on Finch, Hope and Horizon wards all said that their ward could be noisy and unsettled. Hope and Horizon at St Bernard's were located in a very old building. Staff said that the long, thin layout of Horizon was unsuitable for patient's needs and there was not enough communal space. Ravenscourt and Avonmore at Hammersmith and Fulham both had small

Are services responsive to people's needs?

Inadequate 

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

communal areas that felt cramped. The wards at Hammersmith and Fulham mental health unit shared a large communal dining room where patients had their meals. At Lakeside, occupational therapy took place off the wards in a dedicated part of the building. This area was spacious with facilities for art, pottery, and gardening. There was also a well-equipped gym. On Finch ward at Lakeside, we noticed that many patients spent time standing around in corridors near the nurses' office. Most of the wards had areas where patients could meet visitors or spend some time alone.

- Most patients had a mobile phone. There were payphones on each ward, although these were along corridors and did not provide privacy for conversations. Staff on most wards said that patients could use a cordless phone from the nurses' office if they needed to make a call.
- At each site, patients had some access to outside space.
- Most patients said the food was of good quality and that there was a varied selection of food provided. The average PLACE score for food across the three sites was 90.6%. This ranged from 95.6% at St. Bernard's to 85.4% of Hammersmith and Fulham. The average for the trust was 85.1%. The national average was 91.9%. Each ward had facilities for patients to make hot drinks and snacks whenever they wished.
- Patients were able to personalise their bedrooms, although few patients chose to do so.
- Each bedroom was fitted with a lockable safe. These were small and could not accommodate larger personal items. On Avonmore ward, patients reported recent thefts of personal items from their bedrooms. The manager was investigating these reports.
- Each ward had a programme of creative, therapeutic and recreational groups, as well as supporting patients to engage in physical activities. Patients gave mixed feedback when we asked about these activities. Some patients said the activities were excellent. On Grosvenor, few patients were engaging in activities and some of these patients said the activities were not relevant to them. On Avonmore ward, we found little evidence of activities specifically designed to support patients in their recovery. For example, the records we reviewed did not include evidence of patients having individual

assessments of skills required for daily living in the community. Patients on this ward indicated that activities did not have a sufficient recovery focus to support preparation for discharge.

Meeting the needs of all people who use the service

- Each site had lifts to enable disabled access. Each ward had a bathroom equipped for people with disabilities. At the last inspection we said that patients who are less mobile must have an agreed way to request help from staff from their bedrooms. At this inspection we found that some wards had bedrooms with medical beds and other equipment that were designed for people with physical health needs.
- Information leaflets were available in other languages on request. At Lakeside, staff had placed notices telling informal patients they could leave at the ward exit. These notices were written in five different languages. Staff displayed information about treatment, local services, and patient's rights.
- The trust had arrangements in place to ensure that interpreters were available. However, we found that an interpreter had not supported some patients, even when staff identified this need on the patient's record.
- At each site, there was a range of meals that patients could choose from to meet their specialist health, cultural or spiritual requirements
- There were multi-faith rooms at Hammersmith and Fulham and Lakeside. A chaplain visited wards regularly. Managers told us that visits from ministers from other faiths were arranged if requested.

Listening to and learning from concerns and complaints

- In the year from 1 July 2015 to 30 June 2016, there were 51 formal complaints about acute and PICU services. Investigators fully upheld one complaint and partly upheld a further 20. No complainants referred their concerns to the Parliamentary and Health Service Ombudsman.
- There were 17 complaints about general care, 14 complaints about staff issues and six complaints about detention under the Mental Health Act.
- Information about how to complain was available on the wards. The 'Guide to your stay' given to patients at

Are services responsive to people's needs?

Inadequate 

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

Lakeside included information on making informal comments, formal complaints and provided contact details for the Patient Advice and Liaison Service. Many patients said they knew how to make a complaint and some had done so. Some patients were sceptical about whether managers would listen to their complaints. However, patients were not able to explain why this was the case or give us examples that would support their wariness.

- Staff were familiar with the process to follow if a patient wanted to make a complaint. Discussions with staff and evidence from patient records showed that minor issues were resolved quickly without the patient needing to use the formal complaints procedure.
- Ward managers were involved in investigating complaints. The outcome of formal complaints was discussed at team meetings and at monthly clinical improvement meetings

Psychiatric intensive care unit (PICU)

Access and discharge

- Between 1 January 2016 and 30 June 2016 Askew ward had an average bed occupancy of 93%. Patients from Askew ward did not sleep out on other wards. Patients would only be accepted if a bed was available for them. There had been some use of male PICU beds in the private sector when the trusts PICU did not have a bed available for a patient requiring nursing care in the PICU. Between 1 May 2016 and 31 October 2016, the trust had placed nine women in privately provided PICUs, all were within the London area. Over the same period, the trust had placed four male patients in private providers PICU beds, again all within the London area.
- There were no incidents of PICU patients returning from leave and not having a bed available to them.
- There was no evidence of non-clinical moves on this ward because of bed pressures. Patients stayed on the PICU until they could be safely and appropriately discharged to another ward, for example an acute or recovery ward.
- Staff did not report any challenges in accessing the male PICU beds. At the time of our inspection, nine patients were receiving care and treatment within the PICU.

- Between 1 January and 30 June 2016 there had been no delayed discharges on this ward. The ward was able to access the site discharge co-ordinator for support if there were non-clinical barriers to discharge.

The facilities promoted recovery, comfort, dignity and confidentiality

- Staff used a multidisciplinary room for interviews, ward rounds and CPA meetings. Patients used an activities room under the supervision of the activities co-ordinator or an occupational therapist. There was a large dining area. There was a separate lounge area with comfortable seating and a television. Patients used a small gym off the dining area with staff supervision. A large proportion of staff were trained in the use of the gym equipment so that access could be facilitated when patients requested this. There was no separate quiet room.
- Some patients had their own mobile phones. Staff facilitated access to the office phone that patients could use in private.
- The majority of patients told us that the food was okay, or good. One patient commented that they did not feel the food was of good quality. With staff support, patients were able to access hot drinks and snacks whenever they wished.
- None of the patients had personalised their bedrooms, although they were able to bring personal possessions to the ward. Each patient's bedroom came with a lockable safe.
- A range of groups and activities were available on the ward. Patients we spoke with told us that they felt the activities on offer were relevant to needs. Some patients spoke positively about the music therapy group. An external music therapist facilitated this.

Meeting the needs of all people who use the service

- The ward was located on the ground floor. Adjustments had been made for patients requiring disabled access, some shower rooms were fitted to allow disabled access.
- Some information leaflets were available in other languages on request.
- The trust had arranged access to interpreters. However, we found an instance when the patient's progress notes identified that English was not their first language and

Are services responsive to people's needs?

Inadequate 

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

that an interpreter was required to explain their rights under the MHA to them. However, there was no evidence that an interpreter had then been booked. We flagged this with the ward manager for follow up.

- Patients could choose from a range of meals to meet their specialist health, cultural or spiritual requirements.
- The trust had recently developed a multi faith room. A minister visited wards regularly.

Listening to and learning from complaints

- Between 1 July 2015 and 30 June 2016, two complaints were received about Askew ward, one of which was not upheld.
- Patients knew how to complain, and told us that they felt confident to do so if the situation arose.
- Staff we spoke with knew the process to follow if a patient wanted to make a complaint. Minor issues were resolved quickly without the patient needing to use the formal complaints procedure.
- Some ward managers were involved in investigating complaints. Staff discussed the outcomes of complaints investigations at monthly clinical improvement meetings.

Are services well-led?

Requires improvement 

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.

Our findings

Acute wards

Vision and Values

- Staff knew and agreed with the organisations values. The values were ‘togetherness, excellence, caring and responsibility’. Ward managers said the objectives for their ward reflected these values. For example, wards were seeking to improve communication with patients and carers, take a more collaborative approach to assessing risks and to reduce restrictive practices.
- Staff knew who senior managers were and said they have visited wards. Staff spoke positively about the local service managers and matrons and said they visited often.

Good governance

- Governance arrangements for ensuring the competency of staff were very limited. Supervision and appraisal records were very limited. The average compliance rate for supervision was just 48%.
- Ward managers did not receive any collated data about incidents of restraint, rapid tranquilisation and seclusion. This meant that it was difficult for them to identify trends and themes on their ward, and to track performance overall. Whilst managers could access individual incident forms and care records it was difficult to establish trends and patterns of incidents and seclusions that occurred on the ward. One ward manager said they could not see incident reports for their ward that they had not submitted themselves. Whilst ward managers sent a lot of information to the central governance team in the trust they received very little analysis or feedback.
- Wards gave different responses when we asked about key performance indicators (KPIs). Some managers said their KPIs concerned the assessment of patients within 72 hours of admission. Others said their KPI were about mandatory training, supervision sessions, appraisal and staffing levels. Other KPIs included seven-day follow up and average length of stay. This meant that ward managers could not consistently measure and compare performance across the acute wards. Ward managers attended performance meetings with service managers

and data quality leads. Finance managers also attended this meeting. Managers also attended inpatient transformation meetings to review implementation of policy.

- Ward managers felt they had sufficient authority and support to fulfil their role.
- Any staff member could raise concerns with the ward manager regarding potential risks in the ward environment. Managers could escalate concerns at a local level and include them in the directorate or trust wide risk register if appropriate.

Leadership, morale and staff engagement

- Staff did not feel they had experienced bullying or harassment. Staff were aware of how to whistle blow and felt they could raise a concern without fear of victimisation.
- Staff on most wards said morale was improving. Ward managers felt the trust was doing more to improve the overall morale of staff in general. Some staff felt there was some resistance from colleagues to new ways of working. Staff on one ward said that morale fluctuated and was often not good.
- Ward managers had access to leadership development programmes. Some band five and band six nurses were ‘acting-up’ at the next grade. These staff were being supported by a mentor. Staff said these roles provided good opportunities for leadership development. Some HCAs felt that there was little opportunity for progression. In some instances, this made them feel undervalued.
- Whilst teams worked under pressure, staff felt the teams worked well and this had improved in the last year. Overall staff were generally positive about the support they received from their ward manager and recognised that there was a drive for change and improvement.
- Staff had the opportunity to feedback in the staff survey and at team meetings.

Commitment to quality improvement and innovation

- All accreditation for inpatient mental health services (AIMS) for Kestrel, Kingfisher, Finch, Grosvenor, ECT & PICU had lapsed. The trust currently had no accredited clinical areas.

Are services well-led?

Requires improvement 

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.

Psychiatric intensive care unit (PICU)

Vision and values

- Staff were aware of and were signed up to the trusts values and vision.
- Askew ward did not have individual ward objectives.
- Staff knew who the most senior managers were. The local service manager was a very visible presence on Askew ward. Staff at all levels spoke highly of the local service manager, as did patients. It was less clear that senior managers over the trust had visited the ward recently.

Good governance

- Governance was variable. The manager submitted data to the clinical governance team. However, they were not receiving data back in a form that was useful to assess the performance of the ward and to look at the trajectory toward improvements. This meant there was insufficient information at a ward level to monitor issues relating to the use of restraint, prone restraint, rapid tranquilisation and seclusion. The ward manager had been in post for three months. They were still becoming familiar with systems to monitor performance.
- Key performance indicators (KPIs) including mandatory training, supervision, appraisal and staffing levels were monitored.
- The ward manager said they had sufficient authority to fulfil their role.
- Any staff member could raise concerns with the ward manager regarding potential risks in the ward environment. Ward managers could escalate concerns at a local level and include them in the directorate or trust wide risk register if appropriate.

Leadership, morale and staff engagement

- None of the staff we spoke with raised any concerns or issues about bullying or harassment. Staff we spoke with were aware of the trusts whistleblowing policy and felt confident in using this if required.
- Staff felt that there was a drive for and commitment to making positive change. Staff we spoke with felt that staff morale on Askew ward was good at the moment and they spoke of the satisfaction their work gave them.
- The service had appointed some band five and band six nurses to acting up positions at the next grade. Staff in acting up roles told us that they thought there were good opportunities for leadership development. More generally, staff commented that they received praise from their ward manager and were encouraged to consider leadership roles as they became available.
- Staff on Askew told us there was good team working and mutual support. Staff also felt supported by their ward manager, modern matron and service manager.
- Staff felt locally that they could feedback on services. Staff spoke positively about developments on their wards that the service had introduced since the last inspection. This included involving nurses in assessment for patients referred to the unit, the development of behaviour support plans and a recent focus on reducing restrictive practice on the ward. Staff were also well engaged with the research programme currently taking place on the ward.

Commitment to quality improvement and innovation

- The nurse consultant for the ward had recently secured a £20,000 research grant to pilot a new approach to the assessment and care planning processes. The new approach that was being developed and piloted was an integrated psycho-social approach to assessment and care planning, which would also integrate the new behaviour support plans the ward was also piloting.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The trust was not ensuring the ward environments were safe and the risks to the health and safety of patients were being assessed and mitigated.

The seclusion rooms at the Hammersmith and Fulham mental health unit and Lakeside were not located to ensure the safe movement of patients from the ward to the seclusion room.

The new ligature management policy had not been fully applied, with comprehensive ligature audits for each ward and clear actions for when improvements needed to take place.

The blind spots on Kestrel ward had not all been mitigated through the use of mirrors.

Not all patient risk assessments had been updated following incidents.

Some medication fridge temperatures were outside the correct ranges and this had not been addressed.

Patients from acute wards were sleeping on rehabilitation wards, which compromised the consistency of their care and presented risks as the rehabilitation wards were not appropriate environments.

This was a breach of regulation 12(1)(2)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The trust was not ensuring that equipment used on the wards was properly maintained

This section is primarily information for the provider

Requirement notices

The seclusion room on Finch ward was not well maintained and was unclean.

Furniture and fittings on Lillie ward were not well maintained and parts of the ward were unclean.

This was a breach of Regulation 15(1)(2)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The trust was not ensuring that staff had appropriate systems and process to monitor the quality and safety of the service.

Ward managers did not have had sufficient clear and accurate information to monitor the quality of services being delivered.

Ward managers did not have comprehensive information about seclusions, restraints and other information.

This was a breach of Regulation 17(1)(2)(a)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust was not ensuring that there were sufficient numbers of staff or that staff had appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Supervision sessions were not taking place regularly or were consistently recorded.

Managers were unable to review the quality and content of supervision sessions.

Some staff had not completed appraisals.

Junior doctor out of hours workloads were potentially too high and needed to be reviewed.

This was a breach of Regulation 18(1)(2)