

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 & Hounslow Community Services	Finch Grosvenor Kestrel Kingfisher	TW7 6AF
RKL79	Hammersmith & Fulham Mental Health Unit and Community Services	Lillie Ravenscourt Avon more Askew (PICU)	W6 8NF
RKL53	St Bernard's and Ealing Community Services	Horizon Hope Discovery	UB1 3EU

This report describes our judgement of the quality of care provided within this core service by West London Mental Health Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 Trust and these are brought together to inform our overall judgement of West London Mental Health 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?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



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	8
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	8
What people who use the provider's services say	9
Good practice	9
Areas for improvement	9

Detailed findings from this inspection

Locations inspected	11
Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Findings by our five questions	13
Action we have told the provider to take	36

Summary of findings

Overall summary

We rated West London Mental Health Trust's acute wards and the psychiatric intensive care unit as **requires improvement** because:

- Not all staff knew the incident reporting thresholds, therefore all incidents were not reported.
- Female patients were required to access seclusion on the male PICU ward. The location of the seclusion rooms could compromise patient safety as people had to be supported, whilst in a distressed state to move between floors.
- 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.
- The use of rapid tranquilisation was not clearly recorded on patients' prescription charts on some wards and the monitoring was not always happening.
- Medication was not managed consistently well across all the wards. On Grosvenor ward the controlled drugs register was not always completed accurately.

- All patients did not have physical health assessments completed that were thorough and were followed up in a timely manner including ongoing physical health checks where needed.
- Governance processes across the wards were not working well. Audits were not always identifying issues or being followed up. Some basic checks were not taking place as planned. The quality of record keeping was variable. These could all potentially present a risk to the safety of patients.

However most staff were caring and respectful with patients, recognising their individual needs and there were many positive examples of patients and carers being engaged in their care and the service. Patients had access to a programme of therapeutic activities. Staff had access to appropriate training and supervision. Learning from incidents was shared and used to improve the safety of the care delivered.

Summary of findings

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

Are services safe?

We rated safe as **inadequate** because:

- Not all staff knew the incident reporting thresholds, therefore all incidents were not reported.
- Female patients were required to access seclusion on the male PICU ward. The location of the seclusion rooms could compromise patient safety as people had to be supported, whilst in a distressed state to move between floors.
- 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.
- The use of rapid tranquilisation was not clearly recorded on patients' prescription charts on some wards and the monitoring was not always happening.
- Medication was not managed consistently well across all the wards. On Grosvenor ward the controlled drugs register was not always completed accurately.

However, staffing was generally good and most wards used regular bank staff and rarely used agency staff. Activities were not often cancelled and if leave had to be cancelled, it was usually rescheduled to an alternative time. Most patients had risk assessments completed on admission and updated regularly. Staff were aware of types of safeguarding concerns and the reporting procedures. There were systems in place for staff to learn from incidents.

Inadequate



Are services effective?

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

- All patients did not have physical health assessments completed that were thorough and were followed up in a timely manner including ongoing physical health checks where needed.

However, most patients had a care plan in place that was regularly updated and contained their views, although some wards needed to make improvements. Patients had access to a range of psychological interventions. Staff were up to date with mandatory training and most received regular supervision and had completed their annual appraisal. There was good multi-disciplinary input on the wards. Mental Health Act documentation was generally good although patients rights needed to be explained regularly. Patients had access to an advocate on the wards.

Requires improvement



Summary of findings

Are services caring?

We rated caring as **good** because:

- We observed caring and respectful interactions between staff and patients.
- The majority of patients were involved in their care.
- Family and carers were also involved in patients' care. Staff had a good understanding of patients' individual needs.
- Patients were provided with opportunities to give feedback about the care and service they received.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- Patients could access a range of therapeutic activities on the wards.
- Most patients knew how to make complaints and staff dealt with these appropriately.
- Adequate adjustments had been made for disabled access on the wards or within the unit.
- A variety of information was available in multiple languages.

However the trust should work to reduce the patients admitted to wards and then sleeping on other wards at night due to bed pressures.

Good



Are services well-led?

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

- Governance processes across the wards were not working well. Audits were not always identifying issues or being followed up. Some basic checks were not taking place as planned. The quality of record keeping was very variable. These could all potentially present a risk to the safety of patients.

However staff knew the trust's visions and values and felt they reflected and guided the way they worked as a team and cared for patients. The majority of staff felt supported by their team and manager. There were opportunities for staff to provide feedback to management. Most staff felt able to raise any concerns and that they would be dealt with appropriately.

Requires improvement



Summary of findings

Information about the service

The acute wards for adults 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. The service is 'ageless' and meets the needs of older people with a mental illness.

Lakeside mental health unit had four acute wards. There were two assessment wards: Finch ward for men had 16 beds and Grosvenor ward for women had 17 beds. There were also two recovery wards: Kestrel ward for men had 19 beds and Kingfisher ward for women had 20 beds.

Hammersmith and Fulham mental health unit had three acute wards. There were two assessment wards: Ravenscourt ward for men and Avonmore ward for

women, both had 22 beds. Lillie ward was a recovery ward with 16 beds and was mixed gender. There was one PICU called Askew ward. The PICU had 12 beds and was for men only.

St Bernard's had three acute wards for adults. There were two assessment wards: Horizon ward for men had 14 beds and Hope ward for women had 17 beds. Discovery ward was a recovery ward for men with 16 beds.

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 inspection team

The team consisted of two experts by experience, four inspectors, two Mental Health Act reviewers, two nurses, an occupational therapist, a psychiatrist, and a

psychologist. Six people on the team visited Lakeside mental health unit in Hounslow. The other six people visited Hammersmith and Fulham mental health unit on Claybrook Road. Both teams visited St Bernard's in Ealing.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited all 11 of the 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 57 patients and carers. Collected feedback from 35 patients using comment cards
- Spoke with the managers or acting managers for each of the 11 wards
- Spoke with 59 other staff members; including administration staff, consultant psychiatrists, domestic staff, health care assistants, junior doctors, nurses, occupational therapists, peer support workers, psychologists, social workers, and student nurses

Summary of findings

- Interviewed the clinical director with responsibility for these services
- Attended and observed five multi disciplinary hand-over meetings, a bed management meeting, three ward reviews, a nursing handover meeting, three planning meetings, a community meeting and a carer's meeting
- Looked at 51 care records of patients
- Carried out a specific check of the medication management on eight 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

We spoke with patients and relatives and carers. Most were positive about their experience of care on the wards. They told us that most staff were visible, caring and supportive. The majority of patients were involved in decisions about their care, including physical health, and were given copies of their care plans.

Patients said they were given the opportunity to provide feedback on the service they received and would feel comfortable to make a complaint.

Some patients commented on the poor cleanliness and safety of the wards, particularly at St Bernard's. Some patients told us they would like to have more activities available on weekends.

Overall, patients told us that they felt safe on the wards; although some patients did comment that it could be frightening when some very unwell patients were admitted.

Good practice

- The wards had identified and trained dual diagnosis champions to support patients on the wards. They worked with the local drug and alcohol services who also attended monthly meetings with the community and inpatient teams to share information and learning. Staff were encouraged to attend external dual diagnosis training; one member of staff was completing a master's degree in dual diagnosis.

Areas for improvement

Action the provider **MUST** take to improve

- 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.
- 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.

Action the provider **SHOULD** take to improve

- The trust should review the CCTV on Avonmore ward to make it less intrusive for individual patient bedrooms.

Summary of findings

- The trust should address the blind spots on Kestrel and Lillie wards.
- The trust should support patients to have individual behaviour support plans.
- The trust should ensure that seclusion rooms are clean and the observation glass is cleaned and maintained regularly.
- The trust should ensure medical equipment is properly maintained, repaired promptly and accessible.
- The trust should ensure that safe staffing levels are maintained and there are adequate numbers of staff when teams are supporting patients in the place of safety.
- The trust should ensure risk assessments are updated after an incident.
- The trust should ensure patients' rights under the Mental Health Act are read, understood and repeated where required.
- The trust should ensure that all staff and patients are debriefed after incidents, including post-seclusion debriefs for patients.
- The trust should ensure that patients who are less mobile have an agreed way to request staff help from their bedrooms.
- The trust should ensure that care plans are more consistent in terms of their content, recovery focused and adequately reflect patients' views and that patients are involved in the development of their care plan and offered a copy.
- The trust should review handover and multi-disciplinary meetings across the wards to ensure consistently high standards.
- The trust should ensure more consistent use and recording of the Mental Capacity Act.
- The trust should limit patients sleeping on other wards as a result of bed pressures.

The trust should ensure ongoing staff engagement to support staff to feel part of the trust and able to raise issues of concern.

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
Finch Grosvenor Kestrel Kingfisher	Lakeside Mental Health Unit & Hounslow Community Services
Lillie Ravenscourt Avonmore Askew (PICU)	Hammersmith & Fulham Mental Health Unit and Community Services
Horizon Hope Discovery	St Bernard's and Ealing Community Services

Mental Health Act responsibilities

- Staff completed training on mental health law as part of their mandatory training, this included the MHA. Staff demonstrated an understanding of their role, responsibilities and powers under the Act.
- Most patients had their rights explained and repeated to them and this was recorded in their progress notes. This

was regularly revisited and information leaflets were prominently displayed in communal areas. However at Lakeside audits had been completed on whether patients had been told about their section 132 rights. The audit completed in May 2015 on Grosvenor ward showed that the date rights were read was not recorded for 13 out of 27 patients. In the April 2015 audit on Finch

Detailed findings

ward, 13 of 26 patients did not have documentation of when their rights were read, 17 of these did not have documentation of whether they understood their rights. For nearly all of the patients that lacked capacity or insight, their rights had not been repeated. On Finch ward, we found the documentation of rights and consent to treatment for some detained patients were not completed or comprehensive.

- Most informal patients said they had their rights explained to them and knew that they could leave as and when they wished. Information was displayed on the doors of the wards for informal patients in different languages informing them of their right to leave the ward. The wards also had leaflets about the different Mental Health Act sections, information for informal patients and on patients' rights available in different languages.
- Information was displayed on notice boards about independent mental health advocates (IMHA) on all the wards. There was an advocate located on the three hospital sites and the advocates visited all the wards regularly. Staff could refer patients to the advocate at any time. Staff knew who the IMHA was and how to contact them. Patients knew about the IMHA and one patient who was being supported by the IMHA was able to bring them to the ward round with them.
- There was a MHA administrator at all three inpatient sites who visited the wards every day and provided support with any queries.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had completed Mental Capacity Act (MCA) training, however understanding and application of the MCA varied across the wards. Some training on the MCA was included in the mental health law course. In addition all three units had senior staff deliver bespoke training for the inpatient setting.
- The effective use of the Mental Capacity Act varied between wards. On Hope ward, mental capacity was being assessed well. For example an informal patient had their capacity assessed in relation to a decision about whether they needed a staff escort when they took leave. There was a specific record of the assessment that included the relevant points.
- On Avonmore ward decisions around capacity and consent were not being revisited. We were concerned that this could indicate that staff did not recognise that capacity could fluctuate. Some decisions relating to capacity had not been revisited for some weeks for two elderly patients who were refusing physical health checks.
- On other wards, there was a reluctance amongst staff to carry out capacity assessments, and a preference to refer these to the medics, who may not be the most appropriate person to carry out that decision specific assessment.
- The use of best interest meetings was also varied. For example care records on Grosvenor ward had good documentation of mental capacity assessments however staff said they did not hold best interest meetings for patients.
- There had been patients in the recent past for whom deprivation of liberty safeguards (DoLS) applications had been considered. Staff and ward managers were able to tell us about the trust contact and local authority contacts with whom they could discuss potential referrals.
- There was one patient on Discovery ward subject to an authorized DoLS at the time of our inspection. Staff and the manager could describe the process for making the application.

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

Summary of findings

We rated safe as **inadequate** because:

- Not all staff knew the incident reporting thresholds, therefore all incidents were not reported.
- Female patients were required to access seclusion on the male PICU ward. The location of the seclusion rooms could compromise patient safety as people had to be supported, whilst in a distressed state to move between floors.
- 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.
- The use of rapid tranquilisation was not clearly recorded on patients' prescription charts on some wards and the monitoring was not always happening.
- Medication was not managed consistently well across all the wards. On Grosvenor ward the controlled drugs register was not always completed accurately.

However, staffing was generally good and most wards used regular bank staff and rarely used agency staff. Activities were not often cancelled and if leave had to be cancelled, it was usually rescheduled to an alternative time. Most patients had risk assessments completed on admission and updated regularly. Staff were aware of types of safeguarding concerns and the reporting procedures. There were systems in place for staff to learn from incidents.

there was one blind spot near the entrance door that had not been addressed. On other wards the staff managed observation of the ward environments to keep people safe. On Horizon and Finch wards, there were some convex mirrors in place and staff told us they did regular checks of the area. Risk was also managed by keeping areas such as the bathrooms locked when not in use. The more settled patients stayed in rooms furthest away from the office and patients who needed more support stayed in rooms closer to the office. On Avonmore ward they used mirrors and CCTV to monitor blind spots. However, the position of CCTV on this ward meant that parts of patients' bedrooms were visible on CCTV if their doors were open (not their beds). Patients were not specifically told or made aware that CCTV was able to see into their bedrooms.

- The wards had ligature audits completed in April 2015. These listed a range of rooms or areas within the ward environment and identified potential ligature risks within these areas. Potential risks were red, amber or green (RAG) rated and the action to mitigate or manage the risks were identified. The audits did not include dates when outstanding work would be completed. On some wards some potential ligature risks were not included in the audits. For example, on Hope ward the toilets and shower rooms contained hand towel dispensers, toilet roll dispensers and soap dispensers that all presented potential ligature risks. The ward manager could not adequately explain why these potential ligature risks had not been included in the audit. On some ligature audits, for example on Avonmore and Ravenscourt wards, the identified strategy to address the risk was to replace the item, for example to replace standard door handles with anti-ligature fixtures. On the wards at Lakeside, the taps were due to be replaced and the radiators to be covered. No date for these works had been identified on the risk assessment and the managers we spoke with were not able to tell us when these works were scheduled to happen.

- On each of the wards we visited, staff were able to describe to us the measures in place to mitigate the potential risk of ligatures including individual risk assessments and regular observation. Observations

Our findings

Acute wards

Safe and clean environment

- Most wards had no obvious blind spots which made it difficult for staff to observe patients. However, on Kestrel ward, there were corners and rooms that did not have free line of sight from the corridor. On Lillie ward where

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were recorded by staff on Finch, Kingfisher Grosvenor and Askew wards. There were also enhanced engagement and observation checks for patients requiring a higher level of observation. Staff and ward managers told us that patients who were a higher risk of self-harm would be located in bedrooms closer to the nurse's station. If a patient was assessed as being at risk one-to-one observations could be used to mitigate these.

- On some wards patients had risk assessments that identified they were at risk of self-harm from items such as headphones and mobile phone chargers with regards to the potential risk these may present. However on Askew ward, the psychiatric intensive care unit these items were left unattended in other patients rooms, with the doors open which could mean that other patients who were at risk would be able to readily access them.
- All wards were single sex with the exception of Lillie ward, which was moving towards single-sex accommodation. Male and female patients were nursed in different sleeping areas, and women had access to a female only lounge. Men and women were able to access their bedrooms, toilets and bathrooms without having to walk past accommodation occupied by a different gender.
- The use of physical interventions varied between wards. Some wards had much higher recorded use of physical interventions including restraint and seclusion. The trust informed us that over the last six month period, Finch ward reported 50 incidents of restraint involving 33 patients, and 19 prone restraints that led to eight uses of rapid tranquilisation. Grosvenor ward had 71 incidents of restraint involving 21 patients and 35 incidents of prone restraint that resulted in 18 uses of rapid tranquilisation. This is a high use of prone restraint. Finch had 46 episodes of seclusion for 28 patients; Grosvenor had 29 seclusions for 17 patients. Staff could describe how they used de-escalation techniques and how physical interventions were used only as a last resort. Staff struggled to identify which particular patients might be at a higher risk because of previous known behaviour. We saw no behaviour support plans in the patient records that we looked at. There were a significant number of staff injuries on some of the wards. On Grosvenor ward, there had been 25 incidents over a three month period. Staff on Finch ward had been off work due to patient assaults. Staff told us that this was due to the high acuity of patients coming onto the wards. On Kingfisher ward, staff said physical restraint was rarely used due to the positive engagement they had with patients, building good therapeutic relationships, recognising early warning signs and intervening early to prevent incidents from occurring.
- The location and condition of seclusion rooms varied across the service. At the Hammersmith & Fulham mental health unit, the only seclusion room was located in Askew ward the male PICU. Female patients from Avonmore ward had to pass male bedrooms to be able to access the seclusion room. Each time the seclusion room on Askew ward was used by a female patient an incident report was completed. The trust had recognised this and plans were in place to develop a separate de-escalation room on Avonmore ward; however female patients requiring nursing in seclusion would have to continue to access this facility on Askew ward. This was a breach of same sex accommodation guidance and the trust had commissioned an independent review of the seclusion facility. We looked at seclusion rooms on Finch, Horizon and Hope ward. Each had two-way communication, toilet facilities and a clock that was visible from the room. However, on Hope ward the observation panel was scratched and partially obscured impairing vision. We also noted that the mattress was soiled. The seclusion rooms on Finch and Horizon wards were poorly ventilated. Kestrel, Kingfisher, Ravenscourt, Lillie and Discovery wards did not have access to a seclusion room on their ward. This meant that if patients were assessed as requiring seclusion they had to be supported to move to another ward, on a different level to access this facility. This could have health and safety implications as it would involve assisting a patient who is acutely unwell and may require restraint using stairs. For example, Kestrel ward patients accessed the seclusion room on Grosvenor ward; this occurred 11 times in the last six months.
- There were two incidents in the past six months where patients had to move between hospital sites, from the Hammersmith and Fulham mental health unit to St Bernard's to access seclusion facilities. This was when the seclusion room was already in use at the Hammersmith and Fulham mental health unit. We

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reviewed the records for patient who recently recently experienced this move. Staff had concerns that the appropriate de-escalation techniques had not been used prior to the transfer. There was no documentation about the transfer in the patient's records by the originating ward. There was also miscommunication between the units about who was responsible for raising a safeguarding alert and whether this had been done in a timely manner.

- Each of the wards we visited had a clinic room but these varied in terms of access and checks to equipment. There were emergency medicines and equipment available on all wards. On Grosvenor and Avonmore wards these checks were not happening each day, but every three days. There were a number of items that were missing or broken in some of the clinic rooms. On Avonmore ward, there was a broken suction machine with no date to indicate when it was broken, whether a replacement was requested of when it was due to be repaired. Staff were required to borrow a suction machine from other wards in the unit. The ECG machine was also broken for an indeterminate amount of time. Patients had access to two ECG machines at the Hammersmith and Fulham mental health unit and an ECG through the A&E department at Charing Cross Hospital. Maintenance attended and repaired the ECG machine on the morning of our visit. The clinic rooms on Grosvenor and Finch wards were untidy and the medication cupboards were in no discernable order. On Kestrel ward there was no examination couch, blood pressure machine or scales in the clinic room. An examination couch could be accessed in the clinic room upstairs; a blood pressure machine and scales were in a meeting room. The clinic room on Horizon ward was clean and tidy and there was an examination couch, blood pressure monitor and scales. The drugs cupboard and fridge were all in good order. We saw up-to-date stickers on the equipment in the clinic room to indicate when it was last cleaned; this replaced maintaining a daily checklist. However, the emergency equipment bag and defibrillator had not been checked since 1 March 2015. On Kingfisher ward, the medication cupboard was in good order and stored alphabetically. The room was clean, tidy and well organised. There was no treatment table in the clinic room. All these issues were raised and addressed by the trust during or shortly after the inspection.
- The wards we visited were clean, had good furnishings and were generally well maintained. However, patients on Ravenscourt and Avonmore wards complained that the bathrooms and toilets were often dirty. We visited these on the day of our inspection and found them to be clean. Discussions with staff and patients on Ravenscourt and Avonmore wards identified that they were regularly cleaned by domestic staff. On Grosvenor ward the toilets were sometimes blocked but staff told us that estates were on site and sought to rectify the problem immediately. The lock was also broken on the door to the female sitting room, which had been reported and was waiting to be fixed. The standard of decoration on Finch ward was tired. A shower had mould around the drain and a broken mirror. One of the bedrooms had substantial damage to one wall and the curtains were missing. Staff told us the previous patient had been moved to another ward and another patient had been moved in prior to the repairs being completed. Managers informed us that the curtains had been replaced and the damage to the wall had been reported. They had received some funding to improve the decoration of the bedrooms across the wards at Lakeside.
- Hand washing facilities were available on all of the wards we visited and hand hygiene audits completed. Some patients on Grosvenor and Finch wards said that soap and hand towels in the toilets were not always regularly replaced. They also reported that there were issues with plumbing and toilets being blocked but staff dealt with this promptly when reported. Records for infection control, weekly mattress and legionella checks were completed on the wards. The wards had recently implemented an environmental handover sheet that was checked three times a day and staff could report any maintenance issues.
- Alarm systems were only available in some of the bedrooms on the wards. However, not all patient bedrooms had alarm call systems. This concerned us on Avonmore ward where several older patients with mobility issues were being cared for. There was no alarm system in their bedrooms to call staff if they were in difficulty. Staff we spoke with also raised this as a potential risk. On Ravenscourt ward, staff also commented that the lack of patient call alarms in their bedrooms posed a potential risk.

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- On all the wards we visited appropriate personal alarm systems for staff were in place, with each member of staff having access to a personal alarm.

Safe staffing

- Staffing levels were generally safe across most of the wards we visited. Staff said they felt safe working on the wards. Ward managers were aware of their vacancy levels and were actively recruiting to fill positions. New starters had joined or were due to join over the next few weeks. Staff told us that they used regular bank staff who were familiar with the wards and used agency staff as a last resort.
- Discovery ward had the highest number of vacancies where new recruits had not been identified. At the time of our inspection, there were five nursing vacancies. Additionally, one nurse and one HCA were on long-term sick. Discovery ward was due to close although no date had been scheduled for this. At the time of our inspection, staff reported that there were very few permanent staff left, and that the majority of staff were bank or agency. This had created issues for them regarding continuity and quality of care as some bank or agency had been unwilling to undertake core tasks such as recording or care planning. Staff reported some recent improvement with the use of more regular bank and agency staff.
- Ward managers were clear about their staffing establishment. Most felt this was sufficient and could be adjusted according to patients' needs. Managers told us that on occasions that they were not able to get the right disciplines in the right numbers and this did have an impact on the service provided. For example, some wards were allocated two registered nurses on a shift. When qualified members of staff were required to attend the ward round, meetings or administer medication, this could mean that for periods during some shifts both nurses were fully occupied. The staffing levels on the ward could also reduce if staff had to respond to an alarm, support a patient in the place of safety or transport a patient to another unit.
- Managers could adjust staffing levels if more than one patient was on one-to-one observations and depending on occupancy and acuity. Most ward managers felt they had appropriate flexibility to book additional staff when needed. However, they commented that it could be

difficult to get bank or agency staff at short notice, so that whilst in theory they could increase their complement as needed in practise this was more problematic. We saw that managers and staff were visible on the wards during our visit and were present in the communal areas of the wards.

- Patients generally said there were enough staff so they could access regular one-to-one time with their named nurse. On Discovery ward this had not been happening because of the high use of bank and agency. At the time of our inspection an action plan was in place to address this, and we saw that in recent weeks one-to-ones had been happening. Patients on all of the wards commented that escorted leave would be rearranged rather than cancelled, although there were a few occasions when this happened. There were also a few occasions when ward activities were cancelled, though this did not happen regularly.
- Alarms were used during the days we visited and sufficient staff attended these incidents and were able to provide physical interventions safely where needed.
- There was access to out of hours medical input for patients if needed. All units had appropriate access to out of hours medical cover.

Assessing and managing risk to patients and staff

- We found most staff completed risk assessments using a standardised risk assessment tool for patients in an acute service. Staff regularly updated these after incidents. For one patient on Avonmore ward a risk assessment had not been updated following recent incidents. However, the incidents were reported in the patient's progress notes and we observed discussion of risk in multi-disciplinary ward reviews and handovers.
- There were posters of items which were not permitted on the wards. Staff were aware of these items and there was a search policy. They screened visitors coming onto the ward and also checked for items during daily environmental checks and random room searches. Drug dogs randomly attended on all three units on all wards every 6 weeks. Informal patients were subject to different searches to detained patients when they returned from leave. There had been an issue with an informal patient bringing unknown medication onto the

Are services safe?

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

ward. The search policy for informal patients was therefore currently under review with a view to bringing it more in line with the search policy for detained patients.

- All staff had completed mandatory training in safeguarding and could explain the different types of safeguarding concerns and the reporting procedures. They were aware of the safeguarding lead for the trust. Safeguarding allegations were appropriately documented and action taken, including referral to safeguarding leads, safeguarding investigations and strategy meetings (where appropriate). We were told about three incidents where a patient had assaulted another patient. In two of the three cases appropriate safeguarding actions had been taken. In a third incident on Ravenscourt ward, whilst the incident had been recorded in the patient records it was not clear that appropriate safeguarding action had been taken. We raised this with the ward manager who took the necessary action whilst we were there.
- The trust had a policy and procedure in place for children's visits and staff were aware of this. A children's visiting room was available off the ward. Children's visits were supervised by staff and only took place after a multi-disciplinary discussion and determined that they were in the child's best interests.
- Medication administration records for a sample of patients on most wards were fully completed however on a few wards there were areas that needed to be addressed. Emergency drugs were available on the ward. Medicines information leaflets were available for people. On Kingfisher and Lillie wards medicine administration was managed well. However a high number of missed doses were recorded on the medical records reviewed on Kestrel ward. Eight out of 18 records had a missed dose documented. The trust informed us following the inspection that they completed an audit of all prescription charts, completed incident forms for any missed doses.
- On Grosvenor ward, the controlled drugs register indicated that 3ml of methadone should be available. However, this was not in the controlled drugs cupboard and could not be located on the ward. Following the inspection the trust informed us that the controlled drug register should have been amended at the 3ml discrepancy was probably due to loss during the measuring process. In January 2015, 26 tablets of temazepam (with no indication of strength or form) were recorded on the controlled drugs register. This medication was not available in the controlled drugs cupboard, and there was no record of what had happened to this medication. Following the inspection the trust informed us that this was a recording error as temazepam did not need to be entered in the controlled drug register. Audits undertaken by staff over the previous three quarters had not identified these issues.
- A spot check of available medicines on the ward indicated that one medicine had passed its expiry date of April 2015, and that another had not been date labelled upon opening to ensure that it was used within the manufacturer's stated timescales. On Horizon ward, prescription charts were fully completed, with no omissions, and patients' allergies were recorded. Pharmacists visited the ward daily and participated in ward rounds. Medicines stocks and emergency drugs were stored safely and were all in date. Although there was a stock list with minimum levels of stocks, the maximum stock levels were not stated, and excessive supplies, 15 boxes, of one medicine, zopiclone, which is a sleeping tablet were on the ward. This was addressed immediately by the trust. One patient was self-administering medicines; however there was no care plan in place for this. Another patient was on leave from the ward, however there was no recorded evidence that they had been given any medicines to take away with them.
- The use of rapid tranquillisation varied between wards, was not recorded or notified consistently and in some cases the physical health checks afterwards may have not taken place. For example on Grosvenor ward a rapid tranquillisation monitoring form completed in June 2015 indicated that two patients had received rapid tranquillisation in the month. However the medicines charts and care records identified that 12 had in fact received rapid tranquillisation. In four of these 12 instances an incident report had not been completed. On at least two occasions when rapid tranquillisation had been administered, follow up physical health checks had not been carried out. On Avonmore ward the last incident of rapid tranquillisation had occurred on this ward on the 29 May 2015. The patient's care records had no record of physical health checks being carried out. On Horizon ward some patients were

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prescribed medication for rapid tranquilisation. The trust policy for the use of rapid tranquillisation states that where medication is prescribed in anticipation of disturbed behaviour the prescription must be written on the 'as required medicines' section of the prescription chart and must clearly state rapid tranquillisation in the indication box. Most patient prescription charts did not follow the policy and comments like 'agitation' were recorded in the indication box. By not stating the indication, the use of rapid tranquillisation could be under-reported by the trust and there was a risk that the appropriate physical monitoring and checks would not be carried after someone had received rapid tranquillisation.

Track record on safety

- There had been 10 serious incidents across the wards since January 2014.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were confident with how to report incidents and said they were encouraged to do so. They could provide examples of incidents that had occurred on different wards across the trust and the outcomes and learnings. For example, there had been a high number of incidents reported in the garden area at Lakeside that was accessed by patients from all wards. The staff created an action plan and implemented allocated times for the patients to access the garden that was supervised and reported a reduction in incidents.
- The trust had systems in place to share learning from serious incidents in this service and within the trust. Staff and ward managers gave examples of discussions in ward rounds and information on the trust intranet.
- However, all staff we spoke with were not aware that they needed to report when using precautionary, low level or secondary holds. Across all of the 11 wards from 1 December 2014 – 31 May 2015 there were only six reports where precautionary holds were used.
- Staff told us that debriefs were held regularly, learning from incidents were discussed every two weeks at the clinical improvement group meetings and vignettes were sent to staff. Some staff had attended and presented at the 'learning lessons' conference. However,

on Avonmore ward, the staff and ward manager stated that debriefs were only something that were happening in the last few weeks. Staff and patients we spoke with said that patients were not always provided with a debrief after incidents. In particular, that post-seclusion debriefs were not always done or documented.

- Staff told us about incidents where the patients and families had been informed when things had gone wrong.

Psychiatric intensive care unit (PICU)

Safe and clean environment

- The PICU service was for men only. However the seclusion room was used by women from Avonmore ward who accessed this by passing male bedrooms which means the provider had technically breached guidance relating to same sex accommodation.
- Equipment used in an emergency was easily accessible in the nurses station. Records indicated that staff had checked the bag of emergency equipment the day before our visit and found items missing. The missing items had been listed and replacements requested. When we talked with staff and examined the logs we could not evidence that staff had checked this bag from November 2014 until the day before our visit. This meant that staff were not clear how long the missing items had been gone. This was addressed by the trust.
- Staff were able to explain how they would respond in the event of an emergency.
- The ward was clean and the furniture was in good condition.
- All the staff carried alarms and could call for assistance if needed. Staff told us that this system worked well.
- The seclusion room on Askew ward had two way communication, en-suite toilet facilities and a clock. However, the observation panel was scratched and partially obscured impairing vision.
- Askew ward was clean with good furnishings. Patients complained that the bathrooms and toilets were often dirty. On the day of our inspection they were clean. Staff and patients on this ward said that they were regularly cleaned.

Safe staffing

Are services safe?

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- The Askew ward manager knew how many staff vacancies there were. New starters had joined or were due to join over the next few weeks. They used regular bank staff who were familiar with the ward and used agency staff as a last resort. However, on the day of our visit, there were two new agency staff on shift. The ward manager said this could be managed.
- On occasion escorted leave was cancelled due to staffing shortages, but this did not happen regularly. On occasions there were not enough registered nurses working. The manager could adjust staffing levels if more than one patient was on one-to-one observations or other specific needs were identified. The ward manager felt they had appropriate flexibility to book additional staff when needed. However, they commented that it could be difficult to get bank or agency staff at short notice, so that whilst in theory they could increase their complement as needed in practise this was more problematic.
- We saw that the manager and staff were visible on the ward during our visit and were present in the communal areas of the wards.
- Patients generally said there was enough staff so they could access regular one-to-one time with their named nurse.
- Alarms were used during the days we visited and sufficient staff attended these incidents and were able to provide physical interventions.
- Physical restraint was used to manage risk but only as a last resort. We asked to see a sample of recent restraint records, but these could not be accessed by the ward or service manager. There were no behaviour support plans in the patient records that we looked at. The manager on Askew ward identified that de-escalation training was something that staff had requested.
- On Askew ward seclusion for detained patients was used appropriately and mostly followed best practice. For example, each period of seclusion was documented with the start time, reason it was required and who had authorised it and for what reasons. Nursing observations were recorded during the period of seclusion and for four patients regular reviews were undertaken that included the reasons seclusion needed to continue. For two patients we could not find records to confirm that regular reviews of seclusion had been undertaken. The time and reason for ending seclusion were recorded for all the patients whose records we examined.
- Sometimes patients using the place of safety area needed to be secluded. The records showed that this happened twice in 2015 but no records could be found for one of these periods of seclusion. The provider could not therefore show who had authorised the seclusion, the length of time the patient was nursed in seclusion, whether regular observations had taken place and whether regular reviews of seclusion had occurred; all of which are required by the MHA code of practice.

Assessing and managing risk to patients and staff

- We found most staff completed risk assessments using a standardised risk assessment tool. However, for one patient on Askew ward, a risk assessment had not been updated following recent incidents. The incident was reported in the patient's progress notes and we observed a discussion of risk in multi-disciplinary ward reviews and handovers relating to this patient and others.
- There were posters identifying items that could not be brought onto the ward. Staff were aware of these items and the trusts search policy.
- Patients' records and information was stored on an electronic patient record system. Staff reported that they had no issues with accessing information.
- All staff had completed mandatory training in safeguarding and could explain the different types of safeguarding concerns and the reporting procedures. They were aware of the safeguarding lead for the trust.
- The trust had a policy and procedure in place for children visiting the ward and staff were aware of this. A children's visiting room was available off the ward. Children's visits were supervised by staff and only took place after a multi-disciplinary discussion determined that they were in the child's best interests.
- Medication administration records were completed appropriately. Medicines were stored safely. Emergency drugs were available on the ward. Medicines information leaflets were available for people. However, for one patient their medicines chart indicated

Are services safe?

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that an asthma inhaler they were prescribed had not been available on four occasions. There was also one recent incident of rapid tranquilisation and there was no record of physical health monitoring occurring.

Track record on safety

- The trust had systems in place to share learning from serious untoward incidents in this service and within the trust. Staff and ward managers gave examples of discussions in ward rounds and information on the trust intranet.
- In response to learning from a serious incident, on Askew ward changes were made to ensure that general observations were always carried out on time.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were confident about how to report incidents and said they were encouraged to do so. However, not all staff were aware that they needed to report when using precautionary, low level or secondary holds. The ward or service manager were not able to access recent incident reports.
- Patients were not always provided with a post-seclusion debrief.

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.

Summary of findings

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

- All patients did not have physical health assessments completed that were thorough and were followed up in a timely manner including ongoing physical health checks where needed.

However, most patients had a care plan in place that was regularly updated and contained their views, although some wards needed to make improvements. Patients had access to a range of psychological interventions. Staff were up to date with mandatory training and most received regular supervision and had completed their annual appraisal. There was good multi-disciplinary input on the wards. Mental Health Act documentation was generally good although patients rights needed to be explained regularly. Patients had access to an advocate on the wards.

Our findings

Acute wards

Assessment of needs and planning of care

- The care records included comprehensive and timely assessments that had been completed on admission. However, on Avonmore ward two patients had not had their care plans updated as their needs changed. One of these patients was identified as requiring an assessment for mobility issues and falls, but these assessments were not carried out. The ward manager said that these assessments were no longer required, but the care plans had not been updated to reflect this. The patient said that they were experiencing difficulties in this area and had requested an assessment.
- Most patients on the ward had a record of a completed physical examination. However, the quality of physical health assessments and follow up varied between wards. At the time of our visit, there were some older patients on Avonmore ward. Two patients over the age of 70 had had complex physical health needs including a diagnosis of breast cancer and Parkinson's disease. For three older patients there was no record in their care records of their physical health needs being assessed. Two of the patients had declined physical health checks, however there was no evidence of a mental capacity assessment being carried out for this decision, or the matter being revisited at all. One patient on Avonmore ward told us that they were concerned about lesions on their arms. The ward manager said that a nurse had reviewed these and decided that no treatment was necessary. There was no record in the patient's notes confirming that this had happened. On Lillie ward there was one patient with physical health needs identified during their physical health assessment, but no record of this being adequately followed up. On Grosvenor ward, patients had physical health assessments but these were not thorough and there was no follow up for further screening. For example, two patients with a high body mass index and there was no evidence of screening for risk factors including diabetes and cholesterol levels. These issues were raised during the inspection and addressed by the trust.
- The quality of care records varied across the wards. Some had a record of patients views. Some patients had a range of care plans in place while others had just one or two. Two care plans on Avonmore road were not up to date. Two were not holistic and one care plan did not contain the patient's views. On Hope ward, all care plans were present, two were not holistic and five were not recovery orientated. One in three care plans on Lillie ward were not recovery orientated. This was concerning as this was a recovery ward. On Horizon ward the assessments, care plans and risks assessments were detailed, of high quality, recovery focused and sensitive to patients' needs. Physical health was documented and patients received copies of their care plan. On Finch ward, care plans generally showed patients' being involved. They were recovery focused with clear goals. The care records on Kingfisher ward were up to date, regularly reviewed and attention was given to the patient's and carer's views. Staff had supported a patient who had been difficult to engage and considerable efforts had been made to provide culturally sensitive care. Grosvenor ward held a care plan workshop for patients to help them better understand the care planning process. Care plans were completed and reviewed weekly.
- We also found that it was not always clear from records whether patients had been offered a copy of their care plan. Awareness of care plans was variable across all wards and sites, with the exception of Discovery ward

Are services effective?

Requires improvement 

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where everybody had been given a copy of their care plan the day before we arrived and was able to show it to us. On other wards, some patients said that they didn't know what a care plan was. Others commented that they did have a care plan but it did not contain their views, and others were aware of their care plan and said that they had participated in its development. Some of the variation could be accounted for by the level of acuity within the patient group. However, the steps staff had taken to involve the patient in care planning and offering of care plans was not documented.

- All trust teams across all sites were using the electronic patient recording system and were therefore able to easily and readily access records.

Best practice in treatment and care

- On Avonmore ward, three patients were prescribed a medicine 'off licence' and on Grosvenor ward, one patient was being prescribed a medication 'off licence' and there was no record that this had been discussed or agreed with the patients. The trust after the inspection had put plans in place to address this immediately and going forward in line with national guidance.
- Avonmore ward particularly had excellent access to psychology input. The patients at Lakeside had access to a range of psychological interventions. However, staff told us there had been a lot of locum psychologists which had been disruptive for patients. There was psychology input available for the unit at St Bernard's.
- An art therapist had weekly sessions St Bernard's and was also involved in reviews. Patients could access art therapy after discharge from the wards. An art therapy workshop was also delivered for staff to help them understand what is offered to patients and also support them to reflect and work as a team.
- On some wards, the health of the nation outcomes scale was used; however patients had been assigned to a cluster that was not appropriate for acute admissions.
- The trust had appointed a dual diagnosis nurse at the Hammersmith and Fulham mental health unit and community services. This was very positive and provided valuable support however staff we spoke with commented that this was not a sufficient resource to address the needs of all the patient group.

Skilled staff to deliver care

- The staff teams included consultant psychiatrists, specialist registrars, senior house officers, nurses, health care assistants, pharmacists, psychologists and occupational therapists.
- There was a high uptake and completion of training. Nearly all staff were up to date with mandatory training. Kestrel ward's staff were 100% up to date. We saw that staff were registered for upcoming courses that required renewal.
- Staff said they were supported and encouraged to access specialised training for their roles and professional development including personality disorder, smoking cessation, dual diagnosis, and carer assessments.
- Staff we spoke with said they received regular supervision sessions and annual appraisals. However, these records were not always updated electronically.
- New staff completed a three-week induction including an orientation to the ward. Staff said this was of a good standard and helped them to feel prepared for their role. We saw completed records of induction on the wards for agency and bank staff.
- Staff across the wards told us that access to informal supervision was encouraged. Staff could also access reflective practice every two weeks with a psychologist. They spoke positively about being able to raise any issues through these sessions.
- There were no staff performance issues and staff sickness was being managed appropriately. On Avonmore ward, the manager was told us how they had dealt with a member of staff who had made a medication error. This staff was retrained, supervised and was then competency assessed before being able to administer medication.

Multi-disciplinary and inter-agency team work

- On all the wards handover meetings happened each morning and they were regularly attended by a range of disciplines.
- The multi-disciplinary patient review meetings were varied. On Hope and Avonmore wards the meetings were consultant led. Patients were asked their views, encouraged to participate in discussions and were involved in decisions. On Hope ward only the doctor

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and nurse attended – no other disciplines. On Avonmore only the doctors and nurse stayed for the whole meeting but other members of team joined only when patients they were working with were discussed. A multi-disciplinary review we observed on Finch ward was well attended by staff from various disciplines. Patients were reviewed in a professional manner, consent to treatment was reviewed and consent to treatment re-assessed. Patients and their carers' views were listened to and their feedback was sought and documented.

- Minutes from team clinical improvement group meetings showed that staff discussed topics including safety, incidents, complaints and other operational issues. Staff we spoke with said they felt listened to, respected and valued by other members of the multi-disciplinary teams, regardless of their professional backgrounds.
- In addition to the multi-disciplinary team handover each morning, there was a nursing handover between each shift. We observed this on Hope ward and noted that each patient was discussed and all relevant information passed on. On Horizon ward, the handover sheet which was completed by night staff was not fully completed. The sections on risk and observation levels were blank for every patient. The following information was also not discussed during the handover, patient's status, observation level, current risks, leave status and confidentiality. During a handover on Kestrel ward, each patient was reviewed in turn and a treatment plan was developed. There were frequent interruptions with staff entering and leaving the office and phone calls being attended to leading to multiple conversations taking place at the same time.
- Staff on Grosvenor ward at Lakeside, said they had strong links with the crisis team and that someone from the team attended care programme approach meetings. They also liaised with the recovery team. However this was more difficult with the Ealing and Hammersmith and Fulham teams compared to the Hounslow teams. Someone from the community team attended the handover on Kingfisher ward every morning for patient updates. At the Hammersmith & Fulham mental health unit, many of the patients were from Ealing. Each of the wards commented that they did not have such strong links with community teams outside of their borough, and that sometimes it was difficult to get out-of-area

care co-ordinators to attend meetings. However, staff knew who the out-of-area care co-ordinator was, and ward staff were in contact with them. This was echoed at St Bernard's, where staff said they had strong links with teams in their borough but not with those outside of their geographical catchment area.

- On Hope ward at St Bernards, the team spoke of their strong links with the local home treatment team and felt that as a result of this they were able to discharge patients sooner. Access to social workers was limited, and on some wards, for example Hope the ward manager had taken on a lot of the work relating to one patients social circumstances.
- Lakeside had an accommodation manager to support patients with securing accommodation. A local voluntary organisation also assessed patients for supported housing and provided peer support services. On Grosvenor ward, they provided coffee mornings and a swimming group.
- The wards worked with the local drug and alcohol support services who attended the wards to refer patients with identified needs.

Adherence to the MHA and the MHA Code of Practice

- Staff completed training on mental health law as part of their mandatory training, this included the MHA. Staff demonstrated an understanding of their role, responsibilities and powers under the Act.
- Most patients had their rights explained and repeated to them and this was recorded in their progress notes. This was regularly revisited and information leaflets were prominently displayed in communal areas. However at Lakeside audits had been completed on whether patients had been told about their section 132 rights. The audit completed in May 2015 on Grosvenor ward showed that the date rights were read was not recorded for 13 out of 27 patients. In the April 2015 audit on Finch ward, 13 of 26 patients did not have documentation of when their rights were read, 17 of these did not have documentation of whether they understood their rights. For nearly all of the patients that lacked capacity or insight, their rights had not been repeated. On Finch ward, we found the documentation of rights and consent to treatment for some detained patients were not completed or comprehensive.

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.

- Most informal patients said they had their rights explained to them and knew that they could leave as and when they wished. Information was displayed on the doors of the wards for informal patients in different languages informing them of their right to leave the ward. The wards also had leaflets about the different Mental Health Act sections, information for informal patients and on patients' rights available in different languages.
- Information was displayed on notice boards about independent mental health advocates (IMHA) on all the wards. There was an advocate located on the three hospital sites and the advocates visited all the wards regularly. Staff could refer patients to the advocate at any time. Staff knew who the IMHA was and how to contact them. Patients knew about the IMHA and one patient who was being supported by the IMHA was able to bring them to the ward round with them.
- There was a MHA administrator at all three inpatient sites who visited the wards every day and provided support with any queries.
- On other wards, there was a reluctance amongst staff to carry out capacity assessments, and a preference to refer these to the medics, who may not be the most appropriate person to carry out that decision specific assessment.
- The use of best interest meetings was also varied. For example care records on Grosvenor ward had good documentation of mental capacity assessments however staff said they did not hold best interest meetings for patients.
- There had been patients in the recent past for whom deprivation of liberty safeguards (DoLS) applications had been considered. Staff and ward managers were able to tell us about the trust contact and local authority contacts with whom they could discuss potential referrals.
- There was one patient on Discovery ward subject to an authorized DoLS at the time of our inspection. Staff and the manager could describe the process for making the application.

Good practice in applying the MCA

- Staff had completed Mental Capacity Act (MCA) training, however understanding and application of the MCA varied across the wards. Some training on the MCA was included in the mental health law course. In addition all three units had senior staff deliver bespoke training for the inpatient setting.
- The effective use of the Mental Capacity Act varied between wards. On Hope ward, mental capacity was being assessed well. For example an informal patient had their capacity assessed in relation to a decision about whether they needed a staff escort when they took leave. There was a specific record of the assessment that included the relevant points.
- On Avonmore ward decisions around capacity and consent were not being revisited. We were concerned that this could indicate that staff did not recognise that capacity could fluctuate. Some decisions relating to capacity had not been revisited for some weeks for two elderly patients who were refusing physical health checks.

Psychiatric intensive care unit (PICU)

Assessment of needs and planning of care

- The care records showed that comprehensive and timely assessments had been completed on admission.
- A patient complained on admission of a possible fractured hand after a fight with a patient on their previous ward. It was not clear from the records that we saw that this had been followed up by staff on Askew ward in a timely manner. We raised this with the trust and were reassured that this had been followed through, but that details had not been fully recorded in the patients care notes.
- For two patients there was no record of a physical health assessment being carried out since their admission to Askew ward.
- The quality of care records varied as to whether patients' views were included and the range of care needs addressed. Some patients had a range of care plans in place whilst one patient had only one care plan that had been developed with them whilst receiving care and treatment on the ward.
- It was not always clear from records whether patients had been offered a copy of their care plan. Awareness of

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.

care plans amongst patients was variable. Some patients were aware of their care plans, others commented that it did not reflect their views. Some of the variation could be accounted for by the level of acuity within the patient group. However, the steps staff had taken to involve the patient in care planning and offering of care plans was not documented.

- All trust teams across all sites were using the electronic patient recording system and were therefore able to access records as needed.

Best practice in treatment and care

- The trust's pharmacist visited the ward every day to check prescription charts, provide advice and order medicines. Ward staff said the ward pharmacist provided a good service, identifying when monitoring was needed, and providing advice. There was a regular trust medicines bulletin, which included learning from recent medicines incident.
- Pharmacy staff applied stickers to people's prescription charts when people were prescribed high-dose antipsychotic medicines, to remind ward staff to carry out the necessary monitoring, and there were also stickers reminding staff to record the administration of depot injections on people's electronic records as well as on their prescription charts. Although the pharmacists identified when monitoring was needed, it was difficult to check whether this had been carried out, as the pharmacists and doctors told us they did not have access to online blood tests results and relied on receiving paper copies which were scanned into people's electronic records.
- Patients had access to a range of psychological interventions.
- Askew ward used the health of the nation outcomes scores.

Skilled staff to deliver care

- The Askew ward team included a consultant psychiatrist, senior house officer, nurses, health care assistants, pharmacist, psychologists and occupational therapists. Staff were also able to access a specialist dual diagnosis nurse on site who specialised in substance misuse issues.

- There was a high uptake and completion of training. Nearly all staff were up-to-date with mandatory training. Where this was not the case the manager was able to explain the reasons for this, for example, absence due to maternity leave. We saw that staff were registered for upcoming courses that required renewal.
- Staff were supported and encouraged to access specialised training for their roles and professional development for example, personality disorder. However some staff commented that they could not access this training because of staffing pressures.
- Staff received regular supervision sessions and annual appraisals.
- New staff completed a three-week induction including an orientation to the ward. This was of a good standard and helped them to feel prepared for their role.
- There were no staff performance issues and staff sickness was being managed appropriately.

Multi-disciplinary and inter-agency team work

- Staff said they felt listened to, respected and valued by other members of the multi-disciplinary teams, regardless of their professional backgrounds.
- We observed the nursing handover meeting when the shift changed. We noted that each patient was discussed and all relevant information passed on.
- Askew ward provided a trust wide PICU service for men. Staff commented that they did not have such strong links with community teams outside of their borough. The manager told us that they were developing links with donor wards not on site by developing a programme whereby nursing staff would carry out assessments of the patient at the referring ward to ensure that the referral was appropriate and would best meet the patient's needs. For female patients who used PICU's in the independent sector, maintaining links with community teams was even more of a challenge.

Adherence to the MHA and the MHA Code of Practice

- Staff completed training on mental health law as part of their mandatory training, this included the MHA. Staff demonstrated an understanding of their role, responsibilities and powers under the Act.

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.

- Consent to treatment and capacity was addressed in ward reviews. Patients had their rights explained and repeated to them as recorded in their progress notes. This was regularly revisited and information leaflets were prominently displayed in communal areas.
- Information was displayed on notice boards about independent mental health advocates (IMHA) on all the wards. There was an advocate located on site at Claybrook Road. Staff could refer patients to the advocate at any time. Staff and the ward manager knew who the IMHA was and how to contact them. Patients knew about the IMHA.
- There was a MHA administrator at the Hammersmith and Fulham mental health unit and ward staff were able to identify this person and confirmed that they were available and contactable regarding MHA queries.

Good practice in applying the MCA

- Staff had completed Mental Capacity Act (MCA) training, however understanding and application of the MCA varied amongst staff on the ward. We found reluctance amongst some staff to carry out capacity assessments, and a preference to refer these to the medics, who may not be the most appropriate person to carry out that decision specific assessment.
- The ward manager was able to tell us about the trust contact and policy relating to Deprivation of Liberty Safeguards. However, this was unlikely to be required as all patients on the PICU were detained under the MHA.

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- We observed caring and respectful interactions between staff and patients.
- The majority of patients were involved in their care.
- Family and carers were also involved in patients' care. Staff had a good understanding of patients' individual needs.
- Patients were provided with opportunities to give feedback about the care and service they received.

Our findings

Acute wards

Kindness, dignity, respect and support

- Most patients were positive about the support they received from staff and said they felt safe on the wards. Most staff were responsive, discreet, respectful and provided appropriate emotional support. Overall staff had a good understanding of patients' individual needs.
- However, on Avonmore ward staff demonstrated variable skills when interacting and responding to patient needs. Whilst we observed responsive, discreet, respectful interactions that provided emotional support, we also observed some poor communication skills demonstrated by some staff whilst interacting with patients. For example, how one member of staff responded to an interaction between a male and female patient in the shared dining space. On another occasion one patient on Avonmore ward became upset and the ward manager had to prompt staff to approach the patient. They queried why they needed to approach the patient and were told this was to provide emotional support.
- On Kingfisher ward, there were positive interactions between patients and staff. Staff were proactive with engaging patients in meaningful activities. There was mixed engagement between patients and staff on Horizon ward. Some staff were seen playing board games and supporting people with their personal care. The atmosphere on Finch ward was pleasant and staff were responsive and engaging well with patients.

- The majority of patients on all wards reported that the staff were respectful, caring and polite. They generally knocked on their bedroom door and announce themselves before entering. There were usually staff available when they needed. Patients on Lakeside said that staff were flexible around meals. Staff brought one patient food to their room when they did not feel like eating in the communal area. Another patient said staff warmed up their food if they didn't feel like eating it at dinner time. Finch ward did not have a set breakfast time so patients could eat flexibly in the mornings.
- There was some variation, with patients commenting that some staff were more respectful than others, or more approachable. However on Avonmore, three of the patients we spoke with commented that they did not feel that staff were approachable, and were not compassionate. These patients also commented that staff were rude in the way that they spoke with them. The comment cards from Avonmore were more positive with four out of five patients complimenting staff. Some patients we spoke with on Discovery ward said that they had experienced aggression from staff and had witnessed similar situations happening with other patients.
- A small number of patients on some wards also commented that there were not enough staff to spend sufficient time with them.

The involvement of people in the care they receive

- Each of the wards we visited had developed a welcome pack that orientated the person to the ward and service.
- Patients were able to be engaged in their review meetings.
- Most patients we spoke with said they were involved in their care planning and had received a copy of their care plan. Most had been provided with information on admission to orient them to the ward.
- Patients had regular access to advocacy. However, not all patients we spoke with were aware of this service.
- Patients said that the family and carers were involved in the care. Staff knew who patients' families were, how to contact them and any family issues, such as housing and potential safeguarding. Where appropriate and with the patients agreement family were involved in ward

Are services caring?

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

reviews. Horizon ward held a monthly meeting for carers to meet, raise any concerns, be informed of support available, complete a carers assessment and provide feedback. This was well attended by carers and staff.

- On some wards peer support workers were in place to support patients.
- Service user representatives regularly visited all of the wards at Claybrook Road and gave feedback. However, ward managers and staff could not tell us anything specific that had changed as a result of this.
- There were 'tree of hope' displays on the wards we visited. Patients wrote comments when they leave the ward to provide hope for patients on the ward.
- Patients chaired and recorded the community meetings and were involved with daily planning meetings on the wards.
- The wards collected feedback from patients regularly on the wards. Staff developed action plans based on the feedback, which were displayed on the wards.
- We did not see evidence of any patients having advanced decisions in place.

Psychiatric intensive care unit (PICU)

Kindness, dignity, respect and support

- Most patients were positive about the support they received from staff and said they felt safe on the ward, some did however comment that the environment could sometimes feel unsafe because people could be very unwell. We observed that most staff were responsive, discreet, respectful and provided appropriate emotional support.

- The majority of patients reported that staff were respectful, caring and polite. They generally knocked on their bedroom door and announced themselves before entering. There were staff available when patients needed them. On the day of our visit staff were proactive in engaging patients in board games. The atmosphere of the ward was generally relaxed. We observed staff being responsive and engaging well with patients.
- Staff had a good understanding of patients' individual needs.

The involvement of people in the care they receive

- The wards had developed a welcome pack that oriented the person to the ward and service. Patients confirmed they had been provided with a copy of this.
- Most patients said they were involved in their care planning and had received a copy of their care plan. Patients we spoke with were aware of advocacy services and information relating to this service was displayed on the ward.
- Staff knew who patients' families were, how to contact them and any family issues. Where appropriate and with the patients agreement family were involved in ward reviews.
- Service user representatives regularly visited Askew ward and provided feedback. However the ward manager and staff could not tell us anything specific that had changed as a result of this.
- Patients chaired and minuted the community meetings and were involved with daily planning meetings on the wards.
- We did not see evidence of any patients having advanced decisions in place.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated responsive as **good** because:

- Patients could access a range of therapeutic activities on the wards.
- Most patients knew how to make complaints and staff dealt with these appropriately.
- Adequate adjustments had been made for disabled access on the wards or within the unit.
- A variety of information was available in multiple languages.

However the trust should work to reduce the patients admitted to wards and then sleeping on other wards at night due to bed pressures.

Our findings

Acute wards

Access and discharge

- Patients were admitted where there was a bed available across the trust. They were not always admitted to a bed in their catchment area if one was not available. It could be difficult for friends and family to visit patients if they were transferred to another unit in a different borough from where they lived. At the time of our visit, there were eight patients from Ealing on Kestrel ward in Hounslow. Staff tried to work with patients and families and facilitate a transfer between units where possible.
- Staff felt under pressure due to the pressure on beds. They were concerned about the availability and closure of beds. St Bernard's did not have a female recovery ward, which meant patients were transferred to Lakeside or the Hammersmith and Fulham mental health unit. Finch ward had 26 patients admitted to 20 beds with six of these patients on leave at the time of our visit. Twenty-four patients were admitted to 20 beds on Kingfisher, with five on leave. Four patients on Horizon were on leave and the ward had not had any contact with one of these patients for over two weeks. Staff said patients were sometimes admitted to the assessment wards due to a PICU bed not being available. During our visit, there was a patient being supported in the seclusion room on Grosvenor ward while waiting to be admitted to a PICU.
- Non-clinical moves occurred between the wards as a result of the pressure on acute beds. This was most likely to happen with an assessment ward moving a patient to a recovery ward. Recovery ward managers on Lillie and Discovery advised that they tried to work with the assessment wards to identify patients who might be most suitable. Both recovery ward managers commented that at times they could be receiving transfers who were still acutely unwell. There were nine recorded patient transfers for non-clinical reasons across the units due to bed management in April 2015.
- When a patient went on leave, their bed was sometimes used for a new admission. If the patient returned from leave and there was no bed available on the ward, the unit coordinator would identify an empty bed elsewhere within the trust as a temporary measure. For example, if a patient returned from leave unexpectedly to a recovery ward, a more settled patient would sleep over on an assessment ward to make a bed available. We were told of examples of this happening across all the assessment wards we visited. Staff said that if a patient needs to return early from leave, efforts were made to increase support in the community to keep the patient at home rather than arrange a transfer to another ward.
- There were patients sleeping on other wards at night. The trust reported that in April 2015 there were 58 occasions when patients did not sleep on the ward they were admitted to at Lakeside. This affected 20 patients. One patient slept on another ward for eight days and another for six. The trust avoided moving people late at night.
- Kestrel ward had eight delayed discharges of people who were waiting for accommodation. Some patients' discharge had been delayed for three months. Kingfisher ward had three delayed discharges for patients with no fixed address. Staff described approaches they took to facilitate discharge including support with repatriation, pet care and deep cleaning patients' homes. Discharge planning began upon admission. Leave periods were routinely tried prior to discharge and supported by the home treatment team and care coordinator.
- We observed a daily bed management meeting at Lakeside. Managers from all wards discussed bed statuses including admissions, discharges, leave and related targets and key performance indicators.

Are services responsive to people's needs?

Good 

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

Spreadsheets were completed during the meeting, saved on a shared drive and a summary emailed to relevant managers. Where needed the trust was placing patients in the independent sector. Two Hounslow patients had been placed in the independent sector at the time of the inspection.

- During the inspection a 17 year old had been admitted to Finch ward because there was no bed available within a specialist adolescent unit. The trust had highlighted this to the commissioners who were responsible for ensuring access to appropriate inpatient facilities. This had been reported as a serious incident and the patient was nursed under one-to-one observation on the ward. Staff managed this appropriately and located an appropriate placement and the patient was transferred.
- The trust operated on a policy that anyone who needed to be admitted to a health based place of safety was not turned away, even if the S136 suite was already in use. This meant that the patient would be taken to one of the assessment wards as a place of safety. The 136 suite at Lakeside was located on Kestrel ward, the male recovery ward. This meant that there were no facilities for females on the unit. Females requiring access to a 136 suite were taken to a room on Grosvenor ward. If the ward was full, patients were asked to sleep over on the Kingfisher ward to make a bed available should there be a 136 admission. This could affect the other patients on the ward and can cause bed management difficulties. As a recovery ward, it could be unsettling when there was a 136 admission. One patient on Kestrel ward said that they were often woken up in the middle of the night and disturbed by admissions to the 136 suite that was located near to their room.

The facilities promote recovery, comfort, dignity and confidentiality

- The reception area at Lakeside was clean and bright. There was information displayed including visiting hours, safeguarding, Healthwatch, and complaints. There was also a suggestion box and feedback forms. There was a family room and multi-faith room available in the main reception area. Some patients at Lakeside told us there was not always a private space available to meet with visitors. People entering the building and then entering onto the wards were required to enter through two different air locks. We observed during our

visit that this caused some delays. Grosvenor ward had a pay phone that was in a locked room. There was also a hair and beauty salon, and occupation therapy kitchen for patients. The pay phones on Kestrel and Finch wards were located in the corridor and did not provide privacy. Staff and patients confirmed that private phone calls could be made in the nurses office or a more private office space.

- At Hammersmith & Fulham, patients could meet visitors in their rooms or in the communal dining area. At Hope and Discovery wards patients could again meet visitors in their rooms or in an interview room. Space on all the wards we visited was very limited.
- At St Bernard's, Horizon ward had a room for the pay phone and computer for patients to use privately. This was kept locked due to ligature risks. Visits took place in the lounge and dining room. All of the rooms on Horizon ward were labelled and had a picture of what the room was for to help orientate patients to the ward. There was a piano on the ward and a spiritual corner that contained numerous items from different religions. Patients on Horizon ward could access activities delivered by the occupational therapist including a weekly breakfast group and paranoia peer support group.
- Patients on all wards had access to outside space.
- Patients reported variability in the quality of food. Thirteen patients particularly commented on the meals provided. Of these, seven said the food was good, okay or improving. The other six felt strongly that the food was terrible. Patients had access to hot drinks on all the wards we visited. On Discovery ward, patients told us that that this only became available a few days prior to our visit. Snacks were available in the evenings for patients.
- Patients at Lakeside and St Bernard's had fob keys to lock their rooms when they left.
- Many of the wards had numerous display boards with information for patients. There were allocation boards detailing each patient's allocated nurse and staffing as well as photos of staff members. Welcome boards displayed information about the ward manager, visiting and protected times and patient advice and liaison services.

Are services responsive to people's needs?

Good 

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

- Patients were overall very positive about the activities on offer. There were activities co-ordinators on some wards and occupational therapy (OT) support on each ward. A range of groups and individual therapeutic activities were available. However, some patients commented that there were not enough activities at the weekends. At Lakeside, OT's and ward staff delivered activity groups that were patient driven, evaluated by patients and new groups were implemented on request based on patients' interests. Activity groups included, relaxation, exercise, dance, pottery, poetry, cooking and art therapy. Finch ward had a pool table and there was table tennis on Kestrel ward. Patients also had access to cards and board games on the wards. On Grosvenor ward, patients could access activities including the gym, pottery and art. Ex-service users volunteered as activity workers to deliver activities on the evenings and weekends. The ward provided daily newspapers for patients.

Meeting the needs of all people who use the service

- Across the services there were some wards that provided access for people with mobility issues. There was a bathroom with some adjustments on Horizon ward, or else patients could access a disabled bathroom on Discovery ward. The disabled bathroom on Kestrel ward had been decommissioned for the past 18 months. Patients could access the disabled bathroom on Finch ward. At Lillie, Ravenscourt and Hope wards, patients could access the wards by lift.
- All information leaflets produced by the trust were available in a range of languages via the trust intranet and could be printed on request by staff for patients. Staff on the wards also spoke different languages.
- A psychologist told us about work they were doing with patients from different backgrounds. For example, they were working with Somali patients to overcome their beliefs around medication. The psychologist also translated calming music into different languages.
- Staff said they could access interpreters when required. During team handovers the need for interpreters was identified, and that these were booked. For one patient an interpreter had been used to explain their rights and to involve them in the development of their specific care plan.

- There were a range of meals to choose from that meant that they could meet the religious and cultural needs of people using the service. On the wards, weekly menus were displayed and included vegetarian and halal options.
- The trust's chaplain visited the wards weekly and contact numbers were displayed on the wards for patients to contact directly. Patients could also arrange for representatives from other faiths to visit.

Listening to and learning from concerns and complaints

- Most patients knew how to make a complaint. Leaflets giving information on how to make complaints were available on the wards. Patients could raise any issues in the daily community meetings. Some patients had made complaints and told us that they were happy with how this had been dealt with and the outcome.
- Staff knew how to deal with complaints and how to direct patients to the patient advice and liaison service. Staff said they addressed informal complaints at ward level and said this was recorded in patients' individual progress notes. There was no central recording system for informal complaints. Grosvenor ward kept a folder for compliments and complaints. Learning was discussed during supervision and team meetings.

Psychiatric intensive care unit (PICU)

Access and discharge

- Askew ward provided trust wide PICU facilities for male patients. The ward manager also assessed and facilitated access to female PICU facilities. The trust did not have female PICU facilities at the time of this inspection, and was spot purchasing these beds on an as required basis.
- The ward manager expressed pride that the service did not turn away any male patients requiring nursing in the PICU, but conceded that to be able to do this there were often occasions when donor wards would be asked to accept a patient from the PICU to facilitate a bed being available.
- The ward manager acknowledged that whilst every effort would be made to locate a female PICU bed when needed within London, this was not always possible and could result in an admission many miles from home.

Are services responsive to people's needs?

Good 

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

- Staff we spoke with described how discharge planning began upon admission, with patients being discharged to an assessment or recovery bed within the trust when their mental health improved.

The facilities promote recovery, comfort, dignity and confidentiality

- Askew ward was clean and bright and well maintained. New furniture was in the process of being ordered for the ward, and some examples of the new furniture were on the ward for patients to try out and give feedback.
- Patients could meet visitors in the communal space on the ward. However space on the ward was generally limited.
- Patients had access to hot drinks on all the wards. Patients reported variability in the quality of food. Some made positive comments about the meals provided whilst others were not happy with the quality of meals provided.
- The ward had numerous display boards with information for patients. There were allocation boards detailing each patient's allocated nurse and staffing as well as photos of staff members. Welcome boards with information about the ward manager, visiting and protected times and patient advice and liaison services were available.
- Patients were overall very positive about the activities on offer. There was an occupational therapy assistant working on the ward. A range of groups and individual activities were available. Patients also had access to cards and board games on the ward. A small gym was also located on the ward that patients could access with supervision. The ward provided daily newspapers for patients. There was supervised access to outside space for fresh air.

Meeting the needs of all people who use the service

- The ward was based on the ground floor, and some bathrooms had been adjusted to meet the needs of disabled patients.
- All information leaflets produced by the trust were available in a range of languages via the trust intranet and could be printed on request by staff for patients. Staff on the ward also spoke different languages.
- Staff said they could access interpreters when required. Patients we spoke with said that there were a range of meals to choose from that meant their religious or cultural needs could be met. On the ward, weekly menus were displayed and included vegetarian and halal options.
- Patients could access the trust's chaplain and representatives from other faiths. We were given an example on Askew ward where a patient told us that they had requested a Hindu priest, but that there had been delays in their request being responded to.

Listening to and learning from concerns and complaints

- Patients knew how to make a complaint. Leaflets were available on the ward about how to make a complaint. Patients could raise any issues in the daily planning meeting and in community meetings.
- Staff knew how to deal with complaints, and about the trust's complaints process and the patient advice and liaison service. Staff said they addressed informal complaints at ward level, with learning from complaints discussed at team 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.

Summary of findings

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

- Governance processes across the wards were not working well. Audits were not always identifying issues or being followed up. Some basic checks were not taking place as planned. The quality of record keeping was variable. These could all potentially present a risk to the safety of patients.

However staff knew the trust's visions and values and felt they reflected and guided the way they worked as a team and cared for patients. The majority of staff felt supported by their team and manager. There were opportunities for staff to provide feedback to management. Most staff felt able to raise any concerns and that they would be dealt with appropriately.

Our findings

Acute wards

Vision and values

- Staff we spoke with knew the trust's vision and values and felt they reflected and guided the way they worked as a team and cared for patients.
- Staff were less clear about the wards objectives and how these tied to the organisations values. On Lillie ward, the ward manager was very clear about the ward's values and how these related to the trust's values.
- Staff spoke positively about the new senior management team, in particular the director of nursing and deputy director of nursing, and that they have visited the units and were supportive and approachable. This had been an improvement compared to previous senior management, who they were not familiar with and they felt positive changes had been made.
- The chief executive and director of nursing attend all three sites regularly. Each unit holds a monthly nurse forum. This was open for all staff to raise concerns and provide an opportunity to feedback into service development. Several staff we spoke with found this resource useful.

Good governance

- Data on performance was regularly collected through a range of audits. Ward managers completed 72-hour audits on key performance indicators regarding patients' admissions. We saw that action plans were in place to address areas for improvement. Managers told us they were contributing to developing a streamlined self-assessment tool to reduce duplication.
- Some wards were well managed. Managers had the autonomy and time to manage the wards. There were systems in place for learning from incidents. However audits were not always identifying issues such as the medication audit not recognising the missing controlled drugs on Grosvenor ward. Mental Health Act audits identifying that large numbers of patients had not had their rights explained to them had not been followed up. Basic safety checks of emergency equipment had not been taking place with the correct frequency on some wards. Record keeping was variable especially in terms of, physical health checks, monitoring of patients in seclusion and after rapid tranquillisation and physical interventions so it was not possible to tell if the correct checks were taking place to keep people safe and well.
- We found managers were not always able to readily access information and data including incident reports and records around supervision, seclusion and restraint for their wards. This meant they were unable to have complete oversight over the ward. The trust informed us following our visit that ward managers at Hammersmith and Fulham would receive training to support them to develop the skills they need to pull the reports off the system.

Leadership, morale and staff engagement

- Most staff we spoke with across the units said they felt well supported by their teams and managers and that the wards were well led. They felt confident in raising any issues and that they would be dealt with appropriately. Although some staff said they found the job challenging and at times stressful, they were enthusiastic about their roles.
- Staff were aware of the whistle-blowing process. In particular, they were positive about the 'speak up Friday' sessions they could access to discuss any concerns.

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.

- A small number of staff specifically did not feel able to raise concerns without fear of victimisation. There was a wider more generalised view that even if you did raise concerns, senior managers would not listen.
- Staff generally felt supported at a local level by team manager, but some felt disconnected from the wider organisation or senior managers. Some staff commented that they did not feel appreciated by the senior team.
- We saw awards for achievement on the wards we visited. Kestrel ward received an award for excellence in January 2015 for infection control. Ward managers at Lakeside were runners up for quality improvement through research or innovation in 2014 for meeting all five standards with the care plan audit.
- Staff said they were encouraged to access leadership development opportunities and several staff had completed mentorship programmes.
- Some wards were involved with the piloting of 'trusted assessments' prior to this being implemented across all three hospitals. This avoided patients having two assessments done by the liaison psychiatry team and the home treatment team. Instead one assessment was done and was shared. This was being piloted at Hammersmith and Fulham where staff were trusted assessors and if they decided an admission was required then it did not need to be referred or assessed through the home treatment team as part of their gatekeeping function. Ward managers we spoke with said that they were able to feed into the process reviewing this arrangement and felt that their views were listened to. On Hope ward, they were 'trusted assessors' for the home treatment team
- At Lillie ward, staff said that they felt that they had been included in the decision making process to work towards the ward becoming single sex.

Commitment to quality improvement and innovation

- Some of the wards we visited had completed the accreditation for inpatient mental health services programme through the Royal College of Psychiatrists. These included Finch, Kestrel and Lakeside wards which were accredited as excellent and Grosvenor ward.
- The wards had identified and trained dual diagnosis champions to support patients on the wards. They

worked with the local drug and alcohol services who also attended monthly meetings with the community and inpatient teams to share information and learning. Staff were encouraged to attend external dual diagnosis training; one member of staff was completing a master's degree in dual diagnosis.

- Finch ward was the first to pilot 'safewards' interventions in the country. The wards at Lakeside used these techniques to support patients. Staff had developed a list of 'mutual expectations' with patients that were displayed on the ward and discussed with patients on admission. A 'calm down box' was available that included a blanket, stress balls, ear plugs, a soft toy and tea that patients could use.

Psychiatric intensive care unit (PICU)

Vision and values

- Staff we spoke with were familiar with the trust's vision and values and felt they reflected and guided the way they worked as a team and cared for patients.

Good governance

- The ward manager completed and submitted data relating to performance through a system of audits, including key performance indicators such as the completion of assessments within 72 hours of admission.
- Overall, the ward was well managed. The manager had the autonomy and time to manage the ward. There were systems in place for learning from incidents.
- The ward and service manager for the PICU were despite a system being in place, not able to access information we requested relating to incident reports including incidents of restraint. This meant that they could not be sure of having complete oversight over the ward for which they were responsible.

Leadership, morale and staff engagement

- Staff was aware of the whistle-blowing process. Most staff felt well supported by their team and manager and that the ward was well led. They felt confident in raising any issues and that they would be dealt with appropriately. Although some staff said they found the job challenging and at times stressful, they were enthusiastic about their roles.

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.

- Staff generally felt supported at a local level by the ward manager, but some felt disconnected from the wider organisation or senior managers. Some staff commented that they did not feel appreciated by the senior team.
- Askew ward had recently completed a self assessment that staff had been involved in. This had been submitted, and the ward manager advised that an onsite assessment of the PICU was due to be undertaken in November 2015.

Commitment to quality improvement and innovation

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 did not ensure that all ligature risks were included in the wards' ligature audits. Ligature audits did not include timelines for works to be completed and were not updated when works had been completed.

The trust did not ensure that patients' personal items that could present as a ligature risk to other patients were stored securely when they were not in use.

This was a breach of Regulation 12 (1)(2)(a)(b)(d)

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 did not have seclusion facilities located so that they could be used safely. Accurate records of the use of seclusion and physical checks of patients in seclusion were not always available to confirm this had been provided in a safe way.

This was a breach of Regulation 12 (1)(2)(a)(b)(d)

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 did not ensure that use of rapid tranquilisation was always recorded on patients' prescription charts.

Patients did not always have their physical health monitored following administration of rapid tranquilisation.

This section is primarily information for the provider

Requirement notices

Medication was not consistently managed safely across all the wards.

This was a breach of Regulation 12 (1)(2)(a)(b)(g)

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 did not ensure that all patients had their health fully assessed and that where health concerns were identified that these were monitored and treated.

This was a breach of Regulation 12 (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 17 HSCA (RA) Regulations 2014 Good governance

The trust did not have systems and processes which were operated effectively to ensure compliance and address areas where improvements needed to take place to mitigate risks to the health, safety and welfare of patients.

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 17 HSCA (RA) Regulations 2014 Good governance

The trust did not ensure that all staff clearly understood the incident reporting thresholds and reported all incidents.

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