South West London and St George's 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)
RQY07	Springfield Hospital	Ward 2	SW17 7DJ

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

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health NHS Trust.

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Because this was an unannounced focused inspection of one ward, we have not revised the ratings for the core service.

We found the following areas for improvement:

- Staffing levels on the ward were not sufficient to ensure patient safety or to ensure that patients' needs were met. Patients reported that they would like more interaction with staff on the ward. They frequently had to wait for some time for staff to meet their needs.
- Following a serious incident involving a ligature anchor point, some adaptations had been made to minimise future incidents. However, further adaptations had not been made to high risk potential ligature anchor points. Staff had not mitigated the high risk ligature anchor points on the ward sufficiently to ensure that patients were safe.
- Staff had stored medicines at the incorrect temperature on a number of occasions. There was no record that they had taken any action each time the room temperature was above 25 degrees.
- It was possible for male patients to enter the female part of the ward unobserved by staff.
- All patients had their property searched when they returned from leave. Searches were not based on individual patient risks.
- Infection control stickers were available to attach to medical equipment when it had been disinfected, but staff had not been used them.
- The average bed occupancy level on Ward 2 was 111%. This was above the trust average for acute wards. When patients were on leave, their bed was occupied by another patient.
- Patients' care plans did not record that patients had been involved in their development. Patients' care plans were written in a generalised way.

However, we also found the following areas of good practice:

- The ward was in the process of introducing the Dynamic Appraisal of Situational Aggression (DASA). The DASA is an assessment tool to assist in the prediction of violence and aggression.
- Patients found staff caring and compassionate and reported that they were listened to and involved in their care and treatment.
- Risk assessments for patients were thorough and detailed. The multi-disciplinary team used a RAG rating (red, amber, green) system to indicate the level of risk regarding clients.
- The new ward manager had a positive impact on the staff team and quality of care on the ward.

Summary of findings

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

Are services safe?

As this was a focused inspection, the ratings for the core service were unchanged.

We found the following areas for improvement:

- Staffing levels on the ward were not sufficient to ensure patient safety or to ensure that patient's needs were met. The management of ligature risks and facilitation of patients' escorted leave were affected by staffing levels.
- Following a serious incident involving a ligature anchor point in a patient's bedroom, some adaptations had been made to minimise the risk of future incidents. However, other high risk ligature anchor points in patient's bedrooms had not been adapted.
- A number of ligature risks on the ward had been assessed as high risk. Actions to minimise these risks could not be consistently undertaken or were not sufficiently robust for patients at high risk of harming themselves.
- Medicines were stored at the incorrect temperature on a number of occasions. There was no record that any action had been taken each time the room temperature was above 25 degrees.
- It was possible for male patients to enter the female part of the ward unobserved by staff.
- All patients had their property searched when they returned from leave. Searches were not based on individual patients risks.
- Infection control stickers were available to attach to medical equipment to show when it had last been disinfected, but had not been used.

However, we also found the following areas of good practice:

- The ward was in the process of introducing the Dynamic Appraisal of Situational Aggression (DASA). The DASA is an assessment tool to assist in the prediction of violence and aggression.
- Risk assessments for patients were thorough and detailed. The multi-disciplinary team used a RAG rating (red, amber, green) system to indicate the level of risk regarding clients.

Summary of findings

Are services caring?

As this was a focused inspection, the ratings for the core service were unchanged.

We found the following areas of good practice:

- Staff demonstrated a caring and compassionate approach to patients, and were respectful to patients. Patients reported staff were kind and caring.
- Patients reported that they were listened to in ward rounds and were involved in decisions regarding their care and treatment.
- Families and carers of patients were actively involved in patients' care when patients wanted them to be. This included families and carers attending patients' ward rounds.

However, we also found the following areas for improvement:

- Patients reported that they would like more interaction with staff on the ward. They frequently had to wait for some time for staff to meet their needs. Patients concluded that this was due to a lack of staffing on the ward.
- Patients' care plans did not record that patients had been involved in their development. Patients' care plans were written in a generalised way.

Are services responsive to people's needs?

As this was a focused inspection, the ratings for the core service were unchanged.

We found the following area for improvement:

- The average bed occupancy level on Ward 2 was 111%. This was above the trust average for acute wards. When patients were on leave, their bed was occupied by another patient.

Are services well-led?

As this was a focused inspection, the ratings for the core service were unchanged.

We found the following good practice:

- The new ward manager had a positive impact on the staff team and quality of care on the ward. The ward manager actively addressed issues of staff performance, both informally and through formal trust performance systems.
- The multi-disciplinary team had positive working relationships and respected the contribution which each member of the team made.

Summary of findings

- There was a standard agenda for staff business meetings on the ward. All incidents, safeguarding referrals and complaints were discussed at team business meetings.

Summary of findings

Information about the service

Ward 2 is an 18 bed acute admission ward that admits both men and women.

At the time of the inspection, there were 18 patients on the ward; 15 female patients and three male patients. On the first day of the inspection there were an additional five patients on leave from the ward.

In March 2016 we inspected acute wards for adults of working age and psychiatric intensive care units as part of the comprehensive inspection of the services provided by the trust. At that inspection we rated acute wards for adults of working age and psychiatric intensive care units as good for being safe, effective, caring, responsive and well-led, with an overall rating of good.

Our inspection team

The team that inspected this core service: two CQC Inspectors and a CQC Mental Health Act Reviewer.

Why we carried out this inspection

We inspected Ward 2 at Springfield University Hospital due to a number of areas of possible concern we had become aware of. These included the death of a patient by hanging, a number of safeguarding concerns, and the report of an enter and view visit conducted by a local healthwatch organisation. At the enter and view visit, patients reported they did not feel safe on the ward.

How we carried out this inspection

This was a focused, unannounced inspection of Ward 2 at Springfield University Hospital to assess issues relevant to the concerns reported to CQC. These concerns related to aspects of the CQC key questions of safe, caring, responsive and well-led.

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

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the manager for the ward
- spoke with six other staff members; including nurses, the matron, a doctor, an occupational therapist and an activity co-ordinator
- attended and observed a multi-disciplinary ward round meeting
- looked at seven care and treatment records of patients.
- carried out a specific check of the medicines management on the ward
- looked at other documents relating to the running of the service

What people who use the provider's services say

The patients that we spoke with reported that staff were kind and caring and tried to assist patients whenever possible. However, patients also reported that they would

Summary of findings

like more interaction with staff on the ward. They frequently had to wait for some time for staff to meet their needs. Patients concluded that this was due to a lack of staffing on the ward.

Good practice

- The ward was in the process of introducing the Dynamic Appraisal of Situational Aggression (DASA).The DASA is an assessment tool to assist in the prediction of violence and aggression.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient nursing staff on Ward 2 at all times, to ensure patient safety and to meet patients' needs.
- The provider must ensure that ligature risks on Ward 2 are effectively mitigated.
- The provider must ensure that medicines are stored at the correct temperature, and that action is taken when medicines are stored at the incorrect temperature.

Action the provider SHOULD take to improve

- The provider should ensure that medical equipment is appropriately marked with infection control stickers when it has been disinfected.
- The provider should review the blanket practice of searching all patients on their return from leave.
- The provider should ensure that patients' care plans are individualised and demonstrate patients' involvement in their development.
- The provider should ensure that access to the female area of the ward is restricted and that male patients cannot gain access unobserved.
- The provider should ensure that patients can return to a bed on the same ward when they return from leave.

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

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 2	Springfield University Hospital

Are services safe?

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

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

Our findings

Safe and clean environment

Safety of the ward layout

- The layout of ward 2 did not enable staff to have clear lines of sight. The bedroom corridors on the ward had large panes of glass, which increased staff members' ability to observe patients. However, staff were unable to see around the corners on the bedroom corridors. The ward manager had submitted a proposal for the installation of convex mirrors for these areas.
- The staff had undertaken a comprehensive ligature risk assessment. All of the ligature risks in each room or area of the ward were recorded. The ligature risk assessment was updated annually. A number of ligature points in the dining room, laundry room, occupational therapy kitchen, activity room and corridors were assessed to be high risk ligatures. The risk level was to be reduced by a staff member being in communal areas at all times. However, during the inspection, there were no staff in communal areas on several occasions for up to 15 minutes. This was due to a lack of staff available to supervise communal areas at all times. The dining room and male lounge were also recorded as being able to be viewed from the nursing office. However, they could only be partially viewed from the nursing office. The actions to minimise ligature risks in communal areas did not fully reflect the ward environment or the availability of staff.
- The ligature risk assessment also recorded a number of ligature risks in patients' bedrooms, which had been assessed as high risk. Work had taken place to reduce some ligature risks in patients' bedrooms, such as sealing the edges of notice boards and the installation of ligature free taps. Following a serious incident, doors to patients' ensuite bathrooms had been removed and replaced with plastic curtains. However, there had been no adaptations to any of the patients' bedroom doors to minimise similar ligature risks.
- The ward had female and male bedroom corridors and separate male and female quiet rooms. Due to the high number of female patients (15 of the 18 patients were women at the time of the inspection), some of the male bedrooms were being used by females. The plan to temporarily change some male bedrooms to female bedrooms had been risk assessed. There was a door between the male and female bedroom areas.However, this door could not be locked because it was a fire exit and the area around it could not be easily observed. This meant it was possible for male patients to enter the female area unobserved.

Clinic room and equipment

- The clinic room on Ward 2 had a range of medical equipment, which had a maintenance check annually. The equipment to check patients' blood glucose was tested weekly for accuracy. Stickers were available to apply to medical equipment to indicate that they had been disinfected. However, none of the medical equipment displayed any stickers. In addition, one type of tubes for blood tests had passed their expiry date.

Safe staffing

Nursing staff

- The staffing levels on Ward 2 were two registered nurses and two health care assistants (HCAs) during daytime and night shifts. In addition, a registered nurse also worked 9am to 5pm. When a patient required continuous observation by a member of staff, this was undertaken by staff working the shift. Additional staff members worked when more than one patient required continuous observations.
- Ward 2 had three vacancies for registered nurses. All of these posts had been recruited to and the new nurses were awaiting completion of recruitment checks. When shift vacancies arose, the ward used bank or agency staff. In the previous three months, five shifts for registered nurses had been unfilled. On two ocasssions, these shifts had been filled by HCAs. Three HCA shifts had been unfilled.
- The sickness rate for Ward 2 was 10.8% in the month before the inspection. The sickness rate was affected by two registered nurses on long term sickness and a HCA who was sick for one month. Two of these episodes of sickness were related to patient incidents.

Are services safe?

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

- The ward manager was able to book additional nursing staff to work when this was required for specific reasons. Each weekday morning, the matrons and ward managers attended a meeting to discuss bed management and review staffing levels on the wards.
- Staffing levels on the ward were not safe or sufficient to effectively meet patients needs. Four staff and five patients reported that there were not enough nursing staff to meet patients' needs. Three patients reported that they had not had regular, or any, one-to-one time with nursing staff since their admission. Four patients' care and treatment records did not record patients having one-to-one sessions with nursing staff. Some patients were detained under the Mental Health Act and had section 17 leave from the ward. Due to shortages of nursing staff, staff were often unable to facilitate patients' escorted secion 17 leave. Patients' relatives or carers were asked to attend the ward to facilitate the patients' section 17 leave. There were not enough staff to supervise, or be available to, patients in communal areas of the ward at all times. The design of the ward meant that staff had to be in the central communal area to observe all areas of the ward and maintain safety. This was so that staff could observe some ligature points on the ward. When a staff member was required to undertake continuous observations of a patient in the evenings or weekend, three staff were available for the other patients on the ward. This number of staff was not sufficient to safely restrain a patient, if necessary. Also, one of those staff members was a member of the service emergency team. This meant that they would respond to emergency alarms on other wards and undertake seclusion reviews. This would leave two staff for almost all of the patients. Shortly after the inspection, the trust increased the number of nursing staff on the ward.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed seven patients' care and treatment records. Staff completed a thorough and detailed risk assessment of each patient when they were admitted to Ward 2. Patient risk assessments included risks of aggression and violence, self harm and risks related to patients' physical health. Patients' risk assessments were reviewed and updated following risk incidents.
- The multi-disciplinary team used a RAG rating (red, amber, green) system to indicate the level of risk regarding clients. The assessment leading to the RAG rating included patients' level of distress and the number of recent incidents involving the patient. The severity of patients' symptoms and if the patient was physically unwell also contributed to the RAG rating. Patients were automatically rated red (the most serious level of risk) when admitted to the ward and whilst they were being assessed. The red RAG rating meant that patients were observed more regularly by nursing staff. One patient had a RAG rating rating of red, and had two nursing staff continuously observing them.
- The ward was in the process of introducing the Dynamic Appraisal of Situational Aggression (DASA) the month following the inspection. The DASA is an assessment tool to assist in the prediction of violence and aggression. Use of the DASA in inpatient wards is recommended by the NationalInstitute for Health and Care Excellence.

Management of patient risk

- All patients had their property searched when they returned from leave to the ward. This was a blanket practice. The need for individual patients to be searched was not based on individual risks. However, patients were able to keep and use their mobile phones on the ward, unless this presented a risk to an individual patient. Where there was a risk, the patient could not keep their mobile phone.

Use of restrictive interventions

- In the previous three months, there had been 11 incidents involving the physical restraint of patients. Two of these incidents involved the patient being placed in the prone restraint position. Four incidents of restraint involved the the patient being administered rapid tranquilisation.
- In the previous three months, there had been three incidents of a patient being placed in seclusion. There was no seclusion room on Ward 2, and the seclusion room on the psychiatric intensive care unit was used.

Safeguarding

- Staff were able to identify when a safeguarding referral may be necessary, and were encouraged to make a referral if they were unsure. The multi-disciplinary team

also discussed when a patient may be at risk and considered whether a safeguarding referral should be made. When safeguarding investigations involved patients' care on the ward, any changes required following the safeguarding investigation were undertaken. The management team on the ward did not monitor the progression of safeguarding referrals, but had discussed plans to do so.

Medicines management

- There was sufficient stock of a range of medicines, which were stored in locked medicine cabinets or a medicines refrigerator. All of the medicines checked were within their expiry dates. The temperature of the medicines room was recorded daily. However, the temperature of the room had been above 25 degrees on a number of occasions in the previous six weeks. The increased temperatures had been recorded for three periods of six days, four days, and nine days. There was no record that staff had taken action each time the temperature was above 25 degrees. When non-refrigerated medicines are stored above 25 degrees this can affect their effectiveness. Due to the room temperature in the clinic room, the medicines refrigerator had been moved to an adjoining examination room. The medicines refrigerator had been recorded as over eight degrees twice in the previous week. This was above the required temperature, and there was no record that action had been taken as a result.

Track record on safety

- There had been one serious incident on Ward 2 in the previous year. The incident had involved the death of a patient by using a ligature anchor point in their bedroom. Staff had been given a copy of the investigation report, and were aware of changes that had been made following the incident, such as the removal of bathroom doors from patients' bedrooms. However, other, similar, high risk ligatures remained in patients' bedrooms.

Reporting incidents and learning from when things go wrong

- Staff reported a range of incidents including self harm, violence and aggression and medicine errors.
- Following the investigation of incidents, changes were made to minimise the risk of the incident being repeated. For example, a patient had left the ward through the pantry area. The maintenance team now checked the door every three months, and staff checked the door daily. A patient returning from a general hospital did not have their new medicines prescribed on their return. To prevent repetition, every time a patient returned from a general hospital, the duty doctor attended the ward to review the patient's medicines.
- Staff received feedback from incident investigations by a number of sources. Incidents in other parts of the trust were fed back to staff in the monthly learning bulletin. Ward managers attended service line meetings, following which they fed back to staff incidents which had occurred in other acute wards in the trust. Incidents, and the learning from them, were e-mailed to staff and discussed in the staff business meeting.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff demonstrated a caring and compassionate approach to patients, and were respectful to patients. Staff interactions with patients were polite and responsive to patients' needs.
- Patients reported that staff were kind and caring and tried to assist patients whenever possible. However, patients also reported that they would like more interaction with staff on the ward. They frequently had to wait for some time for staff to meet their needs. Patients concluded that this was due to a lack of staffing on the ward.

The involvement of people in the care that they receive

Involvement of patients

- Overall, patients' care plans did not show evidence that patients were involved in their care planning. Patients' care plans were written in a generalised way, and some comments from patients were written in language unlikely to be used by patients. However, with the exception of one patient, all patients reported they had been involved in their care planning and had a copy of their care plan. Patients reported that they were listened to in ward rounds and were involved in decisions regarding their care and treatment.
- A weekly community meeting was held for patients to discuss aspects of life on the ward. Areas of discussion included the ward-based activities, food and patients' feeling of safety on the ward.
- Patients were able to provide feedback by using an electronic machine on the ward. The machine had not been functioning for the previous five months, and paper forms had been used instead

Involvement of families and carers

- Families and carers of patients were actively involved in patients' care when patients wanted them to be. This included families and carers attending patients' ward rounds, and accompanying patients when they went on leave.

Are services responsive to people's needs?

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

Our findings

Access and discharge

Bed management

In the previous three months, the average bed occupancy level for Ward 2 was 111%. This was above the average trust bed occupancy level for adult acute wards of 103%. Bed occupancy above 100% meant that when patients were on leave from the ward, their bed was occupied by another patient. Immediately prior to the inspection a patient's relative was told that a patient could not return from leave as there was no bed for them. Staff apologised to the patient's relative and informed them that a bed would always be available if required. However, the bed may not be available on Ward 2.

Are services well-led?

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

Our findings

Leadership

- Ward 2 had recently had a number of interim ward managers. This had led to a lack of stability and consistency on the ward. An existing member of staff had been appointed as the new ward manager. This had a positive impact on the staff team and quality of care on the ward. A number of staff reported that since the new ward manager was in post there had been less incidents and more structure to the ward.
- The ward manager had an excellent understanding of the patient group. They had regular contact with the matron and reported that they were supported well in their role.

Culture

- The multi-disciplinary team had positive working relationships and respected the contribution which each member of the team made.
- Staff reported that they were supported and were able to speak openly about any concerns. However, none of the staff on Ward 2 knew who the Speak up Guardian in the trust was.
- The ward manager actively addressed issues of staff performance, both informally and through formal trust performance systems.

Governance

- There was a standard agenda for staff business meetings on the ward. All incidents, safeguarding referrals and complaints were discussed at team business meetings.
- The ward team had acted on findings and recommendations from incident investigations, complaints and safeguarding. Staff knew about incidents that had occurred and changes made as a result.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was insufficient mitigation of ligature risks on the ward. Medicines were not stored at the appropriate temperature to ensure they remained effective to use. This is a breach of Regulation 12(b)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not deploy sufficient numbers of staff to ensure patient safety and to ensure that patients' needs could be met. This is a breach of Regulation 18(1)