Good

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	Queen Mary's hospital	Laurel ward Lavender ward Rose ward	SW15 5PN
	Tolworth Hospital	Lilacs ward	KT6 7QU
	Springfield Hospital	Ward 1 Ward 2 Ward 3 Jupiter ward	SW17 7DJ

Summary of findings

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

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

We rated the acute wards for adults of working age and the psychiatric intensive care unit as **good** because:

Staff treated patients with dignity and respect. Staff made sure that patients, their carers and families were involved in their care and treatment. Patients had access to independent advocates to support them to raise issues concerning their care and treatment and staff referred patients to advocacy services when required

Staff followed best practice when undertaking the care and treatment of patients. Staff closely monitored the physical health of patients and systems were in place to promptly respond to patients' health needs.

Despite obvious bed pressures to find enough beds for all patients who needed to be admitted to hospital effective systems were in place to deal with these challenges. Efficient systems were in place to plan and facilitate the discharge of patients.

Wards were clean and well maintained with good furnishings and sufficient facilities to ensure that patients' needs were met. There was good infection control.

There were sufficient staff on the wards for wards to be safe and to ensure that patients had leave and attend activities to support their recovery. Staff were properly qualified and experienced to undertake their duties and to support patients' needs. Staff on the wards received good support from management, were supervised and encouraged to develop their skills and knowledge.

Wards were well run by managers who delivered effective leadership to support and motivate their staff. Managers put effective systems in place to help monitor and improve standards. Systems were in place to ensure that staff promptly reported any incidents on the ward and that they then took any actions required to respond to them.

However, not all wards met targets for mandatory staff training. Some care plans for patients' lacked detail in stating their wishes and preferences. Staff did not always ensure where detained patients had not initially understood their legal rights that they then repeated this information sufficiently promptly. Several patients felt that staff were too busy to spend time with them. Staff did not always store or administer medications in accordance with best practice or trust policy. The toilet facilities on one ward compromised patients' dignity. There was scope for more activities to be provided at the weekend.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- All the wards were visibly clean and well maintained, including all clinic rooms, communal areas and patient rooms and washing facilities and toilets. Staff correctly adhered to infection control principles.
- Staff undertook regular assessments of ligature risks on the wards and took steps to reduce the risks from any risks found.
- There were sufficient numbers of staff on the wards at all time to ensure that patients and staff were safe and to meet the needs of patients. This included sufficient clinical cover at night. Systems were in place to ensure that managers were able to book additional staff to meet the needs of each ward.
- Staff promptly and continually assessed the risks to patients and updated risk assessments and care plans following any incidents. Risk assessments were sufficiently detailed to ensure that staff knew and could plan to manage the risk regarding each patient.
- Robust systems were in place to ensure that all staff promptly reported incidents and that managers reviewed the detail of these reports so that appropriate action could be taken.
- Staff demonstrated that they had learned from incidents.
- Staff gave accurate information to informal patients regarding their legal rights.
- Pharmacists met with both staff and patients to ensure that issues regarding medicines and patients' questions were properly addressed.

However:

- Some wards did not meet the trust target for the completion of mandatory staff training.
- There was one incidence of staff not properly recording the administering of a controlled drug to a patient.
- Staff had recorded that the temperature in a clinic room where drugs were stored was higher than national guidelines directed, but did not respond to this.
- There was one incidence of staff not following best practice and trust policy after the rapid tranquilization of a patient.

Are services effective?

Good

We rated effective as **good** because:

Summary of findings

- Staff undertook effective monitoring of all patients' physical health needs and responded to these needs promptly where required.
- Staff delivered patients' care and treatment in accordance with best practice principles.
- Staff kept detailed and up to date care plans of patients and demonstrated the involvement of patients' families and carers.
- Staff were suitably qualified and experienced to meet the needs of patients.
- There was good staff working between different disciplines and they worked together as a team.
- Most staff across the acute wards had completed training in the Mental Health Act and Mental Capacity Act and demonstrated good knowledge of the principles of the acts.
- Staff supported patients to reach independent decisions about their care and treatment.
- Patients had access to independent advocacy services to help them raise issues concerning their care and treatment. Staff made necessary referrals to advocacy services to ensure patients received this support.
- Staff received regular managerial and clinical supervision.
- Staff undertook regular clinical audits on all wards to ensure the effective monitoring and improvement of standards on the wards.

However:

- Some patients' care plans lacked detail regarding their wishes and preferences.
- Staff did not always ensure, where patients had not initially understood their legal rights. when detained, that they then repeated their explanation these rights in a timely manner.
- Some staff were concerned about the lack of psychology services for patients.

Are services caring?

Good

We rated caring as **good** because:

- Most patients said that staff treated them with kindness and respect.
- Staff demonstrated an understanding of individual patients' needs and how to support them
- Robust and effective systems were in place to support the involvement of families and carers in the care, treatment and rehabilitation of patients.
- Staff supported patients to involve themselves in their care and to speak up about their concerns.

Summary of findings

However:

- Some patients said that staff were very busy and did not have time to speak to them.
- At the time of our visit many patients on Jupiter ward walked around or stood alone with little interaction from staff.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Despite the pressures on beds the trust had taken significant steps to address the challenges caused by this problem. This included the effective management of admissions and patients' needs by the acute care co-ordination centre.
- All wards were accessible to wheelchair users and the trust undertook disability audits to ensure that all facilities met the needs of less-abled patients.
- Staff demonstrated that they planned for the discharge of patients and worked efficiently with other services to help facilitate this. This work was made more effective by the employment of discharge co-ordinators. Delayed discharges were consequently low.
- Facilities on all of the wards met the needs of patients.
- Patients said that the food was of mostly good quality and they were able to order meals that met their specific dietary needs.
- There was a diverse range of activities for patients on all wards to support their recovery and return to the community.
- Patients knew how to make complaints and staff supported patients to do this when required. This included the weekly attendance on each ward of a member of the trust's patients' experience team to ask patients if they had any concerns.
- Patients were able to give real-time feedback to ward managers regarding any positive or negative observations.
- Patients were able to access spiritual support to meet their needs.

However:

- The toilet facilities on Jupiter ward did not support the privacy and dignity of patients.
- On Lavender ward the panels in the bedroom doors could not be closed by the patients from inside their rooms.
- The activities provided at the weekend were much less than during the week.

Are services well-led?

Good

We rated well-led as **good** because:

Summary of findings

- Staff were committed to the vision and values of the trust and had patient care at the centre of what they did.
- Senior managers were visible on the wards and provided support and encouragement to ward managers to undertake initiatives and improvements as they saw fit.
- Managers supported their staff, including encouraging personal development, monitoring staff training and by providing regular managerial supervision.
- Managers demonstrated a commitment to monitoring and improving standards of care and treatment on the ward as well as maintaining and improving staff morale.
- Sickness and absence rates among the staff on most wards was low and staff said that they enjoyed working as a team and felt-well supported by senior staff.
- There were numerous opportunities for staff to discuss their work, learn from incidents and develop good practice.

Summary of findings

Information about the service

- Laurel ward is a 23 bed acute ward for men
- Lavender is a 23 bed acute ward for men and women
- Rose is a 23 bed acute ward for women
- Lilacs ward is a 23 acute ward for men and women
- Ward 1 is a 13 bed psychiatric intensive care unit for men
- Ward 2 is a 18 bed acute ward for men and women
- Ward 3 is 20 bed acute ward for men and women
- Jupiter ward is a 23 bed acute ward for men and women

At the previous inspection of these wards which took place on 24 May 2015 we identified several breaches of regulations. On Lilacs ward ligature risk assessment and management was inconsistent and staff did not always recognise risks or know how to manage risks safely. Staff did not always update risk assessments and management plans following incidents. Also, staff did not properly understand how the Mental Capacity Act was applicable to their work. On Lavender ward staff administered 'as required' medicines to some patients every night, but they did not always record the reasons why patients required these medicines. Some equipment on both wards was not maintained on a regular basis to ensure it was fit for purpose. At this inspection all these areas of non-compliance had been addressed.

Our inspection team

The teams that inspected the acute wards and the psychiatric intensive care unit consisted of three inspectors, three nurses, a psychiatrist, a psychologist, two pharmacists, two Mental Health Act reviewers and two experts by experience, who have experience using services.

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

During the inspection visit, the inspection team:

- Visited Laurel, Lavender and Rose wards at the Queen Mary's Hospital site, Lilacs ward at Tolworth Hospital and Wards 1, 2, 3 and Jupiter at the Springfield Hospital site and looked at the quality of the ward environment at all those locations
- Observed how staff were interacting with patients on each ward
- Spoke with 55 patients who were using the services
- Interviewed 8 ward managers and 4 deputy managers.
- Spoke with 59 staff members; including psychiatrist, nurses, health care assistants, occupational therapists, activity co-ordinators and dieticians
- Observed 8 multi-disciplinary meetings
- Observed 5 handover meetings
- Observed 5 community meetings which patients and staff attended
- Attended two groups with patients.
- Reviewed 53 care and treatment records
- Checked the medicines records for every patient on all of the wards.
- Reviewed 45 risk assessments and 30 incident reports
- Read documents on staff training, staff supervision and appraisal, staffing levels and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

Overall patients said that staff were caring and treated them with respect. Staff also supported patients, their families and their carers to be involved in their care and treatment.

Patients said staff explained their rights to them. Patients knew how to raise complaints and received support to do this and they also had regular access to an independent advocate to support them to raise issues concerning their care and treatment.

Patients reported that there was a good range of activities in hospital to support their recovery. Patients also said that the food on the wards was generally of a good quality and met their needs.

However, some patients said that they did not have enough time with their named nurse.

Good practice

- The trust had an acute care co-ordination centre that operated 24 hours a day. This was very effective at ensuring beds were identified in a timely manner for patients who needed to be admitted.
- Wards had allocated discharge coordinators to facilitate communication between the staff team and local services. This meant that patient discharges from the wards usually took place in a timely way.
- Pharmacists met with patients to talk with them about their medicines and answer any concerns they had.
- On Lavender ward there was a worker funded by partner organisations who supported patients' families and carers.
- Staff from the patient experience team, visited the wards on a weekly basis to support people who wanted to raise concerns or make a formal complaint.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff complete their progress towards meeting the trust mandatory training target.
- The trust should ensure that staff store and administer medications, including controlled drugs, in accordance with best practice and trust policy.
- The trust should ensure that, wherever possible, care plans reflect the preferences of each patient.
- The trust should ensure that staff discharge their duty to inform detained patients of legal rights as required by the Mental Health Act and Codes of Practice.
- The trust should ensure there is sufficient access to psychological therapies for patients in line with national guidance.
- The trust should ensure that staff, especially on Jupiter ward appropriately care for patients including undertaking regular interaction with them on the wards.
- The trust should ensure that ward facilities support patients' dignity, especially the toilet doors on Jupiter ward and the viewing panels in bedroom doors on Lavender ward.
- The trust should ensure sufficient activities are provided at the weekend.

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

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Laurel ward Lavender ward Rose ward	Queen Mary's Hospital
Lilacs ward	Tolworth Hospital
Ward 1 Ward 2 Ward 3 Jupiter Ward	Springfield Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Across all three wards, over 80% of staff had received training on the Mental Health Act (MHA). Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice.
- Copies of consent to treatment forms were appropriately attached to patients' medicines charts.
- There was evidence in patient records that staff had explained to patients their rights under the MHA on admission and thereafter. However, there were cases where staff had failed to promptly inform patients of their legal rights.

Detailed findings

- Ward managers told us they received support from a central team who checked that MHA paperwork was correctly completed. This team also audited the records of detained patients regularly and made recommendations for action when necessary.
- Independent Mental Health Act advocates (IMHA) had specific times each week when they visited patients on each ward. The IMHA service displayed information in the wards so patients knew how to contact them. Patients told us they could easily speak to an IMHA about any aspect of their support and treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Across all wards over 80% of staff had received training on the Mental Capacity Act (MCA). Staff we spoke with had a good understanding of the key principles of the MCA.
- There had been no Deprivation of Liberty Safeguards (DoLS) applications from any of the wards.
- Staff generally completed patients' mental capacity assessments appropriately, following procedure and giving complete reasons for their findings. However, several capacity assessments had too little detail and did not adequately explain why staff had reached their conclusions about patients' mental capacity.
- Staff followed correct procedures when making best interest decisions in the interests of patients who they had assessed as not having capacity.

Good

Are services safe?

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

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

Our findings

Acute Wards

Safe and clean environment

- The layout on the wards meant that staff did not always have direct lines of sight. Sometimes staff had taken steps to reduce the risks for patient safety because of this. For example, on Laurel, Lavender and Rose wards staff had placed mirrors in places where there were no direct lines of sight. However, on Jupiter ward staff had not done this and there were many blind spots. Staff had mitigated this by discussing risks based on each persons individual needs and providing higher levels of staff observation where needed.
- Staff undertook regular assessments to identify any ligature risks on the ward so that steps could be taken to reduce those risks. For example, on Lilacs ward staff had identified that window handles and taps in patients' rooms were a risk and the provider had scheduled work to begin replacing them. This work was due to begin two weeks after the inspection. Following a previous inspection of Lilacs ward where inspectors found the ward in breach of regulations regarding the management of ligature risks this was now not the case. For each ward there was an individual comprehensive document setting out the risks to patients due to the ward environment and how staff should mitigate the risks. Mitigation measures included individual risk management plans for each patient and ensuring that staff were regularly in ward areas where there were risks.
- All wards were compliant with the guidance on same sex accommodation.
- The clinic rooms on all the wards were clean and in good order, with all emergency equipment, including for resuscitation and medicines up to date. Records showed that staff checked all medicines and equipment regularly. Fridges for storing medicines were all at the correct temperatures and staff made up to date checks of these temperatures. Staff on ward 2 in Springfield Hospital reported the clinic room fridge did not have any ventilation resulting in it overheating. This had been reported to the trust but it was noted during inspection the request for ventilation had not been actioned. On all wards emergency ligature cutters were located in the staff office as well as the clinic room and all staff knew their location.
- The acute wards did not have seclusion rooms. Where patients became particularly unwell staff used a combination of de-escalation techniques and close observation to manage the situation.
- Staff on all wards adhered to good infection control principles. Hand washing facilities were available throughout the wards and information was posted on information boards regarding the importance of infection control. Each ward had a member of staff who was an infection control lead. They had carried regular audits to ensure staff followed good hygiene practice.
- All wards were visibly clean, were well-maintained and had good furnishings. Cleaning records on all wards were up to date.
- Staff on all the wards had appropriate alarm systems. All staff had carried personal alarms and wards all operated an emergency alarm system to alert staff on adjacent wards when help was required. Rooms on all wards also had wall mounted alarms. Records showed that staff regularly tested all alarms to ensure they were functioning properly.

Safe staffing

- The staffing levels on the acute wards was three qualified nurses and two healthcare assistants (HCAs) working during the day and two qualified nurses and two HCAs at night.
- There were staff vacancies on all wards. The highest of these was Jupiter ward which had five vacancies for qualified nurses. There were very few vacancies for HCAs across all wards. The provider was conducting a recruitment drive to fill these vacancies.
- The wards covered staff vacancies and any staff absences by employing bank and agency staff. Data from the provider covering a period of three months before the inspection showed that the use of bank and agency staff varied across the acute wards. The lowest use was on Lilacs ward where bank and agency staff

Good

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covered 22 shifts during that period, while they covered 123 shifts on Ward 3. Occasionally bank and agency staff were not available to fill shifts on the wards. However the number of unfilled shifts was low across all wards.

- Over a 12 month period prior to the inspection the level of staff sickness levels across was variable. The majority of wards had sickness levels at or under 5%. Three wards had sickness levels above 5% with Ward 2 the highest at 10%. Staff turnover during the same period was low, with most wards having a rate on below 5%. Laurel ward was the highest at 6%.
- Managers on all wards used an electronic roster system to plan their staffing levels up to 8 weeks in advance. This system allowed them to book the appropriate levels of bank and agency staff. Almost all shifts were covered. The majority of bank staff worked on the wards regularly and knew the patients and the ward routines.
- Managers on all wards said that they were able to adjust staffing levels on their wards to meet demands. For example, when patients required close observation managers requested additional staff to undertake the task. Some senior staff at Queen Mary's hospital expressed concern about the size of the wards. The three consultant psychiatrists and three ward managers observed there were currently 23 patients on each ward at the hospital which was above the Royal College of Psychiatrists' recommended maximum of 19 patients for an acute ward. However, they also said that there were sufficient staff numbers on each of the wards at the hospital.
- A qualified nurse was present in the communal areas at all times.
- Staff stated that staffing levels meant that there were enough staff on the wards to allow for nurses to undertake 1:1 sessions with patients. Ward managers said that 1:1 time with patients was a priority and that the work of staff was managed to ensure this happened. This was confirmed by most patients we spoke to who said that they were happy with how frequently they saw their nurse. However, the majority of patients we spoke to on Jupiter ward said that staff were frequently busy when they wanted to speak to them and that they had little 1:1 time with a nurse.
- Staff on all wards said that there were usually enough staff to ensure that patient escorted leave went ahead as scheduled. Managers confirmed they managed escorted leave by viewing the electronic rostering system and planned an escorted leave diary so they could request additional staff to make sure the escorted leave went ahead. Sometimes leave was postponed for a few hours when wards were very busy or unsettled. Patients on all wards confirmed cancellation of escorted leave was rare.
- Staff on all wards said there were enough staff to safely carry out physical interventions. However, one staff member on Lilacs ward at Tolworth hospital reported that requests for emergency help did not always bring immediate help as staff on the adjacent older adult ward could sometimes respond slowly. When asked, a ward manager confirmed that this had happened approximately twice in the past year. The manager had said that following a safety review of the acute wards in trust, where this issue was identified, staff on the older adult ward would shortly begin mandatory restraint training to give them more confidence and the ability to respond to emergencies.
- There was sufficient medical cover during the day and at night. One duty doctor covered Springfield Hospital and another Tolworth and Queen Mary's Hospital sites. This meant there was sometimes a slight delay in a doctor attending the wards in an emergency. To manage this possible delay measures were in place to ensure that nursing staff in an emergency could administer 'as required' medication to patients without the attendance of the doctor. Medical cover also included an on call pharmacist.
- The trust target for the completion of mandatory training was 95%. Some wards were meeting this figure. However, three wards were not. On Laurel ward currently 90% of staff had completed mandatory training at the time of our inspection. On Ward 3 this figure was 84%. On Ward 2 it was 55%. In response to this low figure the ward had put an action plan in place to help ensure that staff who had not yet completed training did so as soon as possible. As part of this plan every fortnight senior management and the ward manager reviewed the progress of staff completing training.

Assessing and managing risk to patients and staff

- The wards did not have seclusion rooms. On Jupiter and Lilacs ward staff said that they did not believe seclusion was therapeutically beneficial for patients or the only method of ensure that wards were safe when patients became very unwell. Staff on these wards said when a patient became particularly unwell they first used de-

escalation techniques to try and verbally calm the patient. If further steps were necessary to keep people safe staff put patients under close observation in their rooms until they had become calmer. Patients were free to leave their rooms in these circumstances. We observed an instance on Laurel ward where a patient became unwell while waiting transfer to an intensive care unit and staff restrained them. After a brief period of restraint staff then kept the patient under close observation, but did not prevent them from moving around the ward. On all wards we looked at records of patients who had been subject to restraint. We found they had not been secluded in their bedrooms or other areas of the ward. Where a patient became very unwell and staff decided that seclusion was the only way to keep them safe they transferred them to the seclusion room on Ward 1.

- The provider gave data regarding the use of restraint on each of the ward for a six month period between May and November 2015. This showed that the use of physical restraint varied widely across the acute wards. During this period the highest figure was on Jupiter ward where staff restrained 22 patients a total of 49 times. The lowest figure for this period was for Lavender ward where staff restrained six patients a total of six times. The use of prone restraint, where staff held a patient face down on a surface to physically prevent them moving, was very low across all wards. We looked at 12 records of patients on Jupiter ward where staff had physically restrained patients. These showed that staff had first employed de-escalation techniques to calm the patient before restraint had occurred.
- We looked at a total of 53 risk assessments across the acute wards. All records we looked at showed that staff had undertaken an initial risk assessment for each patient upon their arrival on the ward. Staff used a recognised tool for assessing risk. The records showed that staff updated patients' risk assessments following incidents to reflect any new risks relating to them. Managers audited the recording of every incident to ensure that staff did this promptly and accurately. During a previous inspection of Lilacs ward inspectors found that the staff were not always updating risk assessments in response to incidents, but they were now doing this. Staff reviewed risks to patients at daily multidisciplinary meetings and at handover meetings. Care records showed that staff amended risk management plans in the light of new information. For example, on Lavender ward, the staff team changed arrangements for home leave and increased the level of observation in respect of patient who was assessed to be at a heightened risk of self-harm.
- Blanket restrictions were in place on the wards. These were in response to identifiable risks. For example, staff banned the possession of certain items such as matches and lighters. Patients said that staff explained the reasons why items were banned and they thought the restrictions were reasonable. On Lilacs ward staff locked all the kitchens. This was following two incidents where unwell patients had injured staff with boiling water.
- Informal patients were free on all wards to leave at any time. Staff gave informal patients information regarding their rights which was clear, concise and legally correct.
- Staff on the wards followed trust procedures on observing patients and searching patients and patient bedrooms.
- We looked at the frequency and how staff administered rapid tranquilization on the wards. This is a procedure where staff give medicines to a patient who is very agitated or aggressive in order to rapidly calm them. Staff used rapid tranquilization very infrequently. Across all acute wards during a six month period between May and November 2015 staff administered rapid tranquilization on average 25 times a month. Staff said they wished to keep instances of rapid tranquilization to a minimum because of the impact on patient safety. Therefore staff always reported an instance of rapid tranquilization as an incident. We looked at six records of rapid tranquilization. These mostly showed that staff had correctly followed best practice and trust policy. However, one record for a patient on Rose ward showed that staff had not undertaken physical observations of a patient after rapid tranquilization. This was not in accordance with best practice or trust policy.
- Staff demonstrated they understood the principles of safeguarding and how to raise safeguarding alerts. Procedures were in place on each of the wards to ensure safeguarding concerns were dealt with without delay and appropriately. For example a patient on Lavender ward had complained that a member of staff had assaulted them. Staff immediately raised a safeguarding alert with the LA and management took appropriate action to investigate the issue.
- Staff generally undertook good medicines management across all wards. Staff prescribed drugs well ensuring that they did not over-medicate patients. Staff mostly

stored medicines appropriately and completed drugs charts correctly. However, on Rose ward records showed that the recorded temperature on one day in the clinic room was 28.4 degrees celsius. National guidelines state that most medicines should be stored at no higher than 25 degrees, but staff had not taken any action in response to this higher temperature. We also checked to see how pharmacists managed controlled drugs as this must be done according to strict policy and procedure. Staff had mostly managed controlled drugs correctly, including storing them securely and properly recording how and when they dispensed them. The pharmacists on each of the wards regularly reviewed the management of medicines, making clinical interventions when required. However, records showed that staff on Lavender ward had not undertaken a required twice-daily check on a particular controlled drug for 10 days. Pharmacists also delivered staff training in response to any issues and further staff training on medicines matters was planned to begin on Rose ward to be given during staff handovers to address any medicines issues related to reported incidents. Pharmacists met with patients following their admission to discuss their treatment as well as at other times when the patients' medicines changed in order to talk about dosage and side effects. In addition, a pharmacist led clinic was being piloted on Lavender ward to allow patients to discuss their medicines for as long as needed with a pharmacist. This service was due to be rolled out to Rose ward. Information on medication was available on all wards in a variety of languages, as well as braille. However, on Lilacs ward where a patient was self-medicating with an inhaler there was no evidence to show that a pharmacist had met with the patient to discuss the risks of its over use. The patient's risk assessment also contained no mention of this. This created a risk of harm to the patient through any excessive use of the inhaler.

- There were dedicated rooms outside the wards where patients could meet child family members. In Springfield hospital a family room was available which had age appropriate toys for young children. This room was clean, well-furnished and had information boards informing visitors of support services and networks available to them.

Track record on safety

- The trust provided data regarding serious incidents that had taken place on the acute wards during a 12 month period between October 2014 and October 2015. There were a total seven serious incidents and each involved a patient death. None of the incidents were classified as a 'never event', which is a serious incident that is wholly preventable.

Reporting incidents and learning from when things go wrong

- All the staff across the wards were familiar with the trust's electronic incident reporting system. This required staff to immediately complete a report detailing what had occurred. A manager then reviewed each report. They had to indicate the level of seriousness of the incident, the type of response required, whether it was necessary for staff to update patients' risk assessments and care plans and whether any training or supervision was also required as a result. For example, managers had to classify whether the incident was also a safeguarding matter that they needed to refer to the safeguarding lead in the hospital, as well as the local authority.
- Staff reported incidents correctly. Across the wards we looked at 24 incidents that staff had documented in patients' notes and saw that staff had then recorded these incidents in the electronic system, followed by appropriate and immediate management review. There was also evidence that staff were alert to potential risks beyond the ward that could affect patients, which they then reported and responded to. For example, on Lilacs ward staff had noticed that a patient on leave had written on social media that they wished to self-harm. Staff recorded this as an incident and took immediate steps to make the patient safe. Staff also reported medicines incidents via the online system. The medicines safety officer was a pharmacist, and passed any incidents reported on the incident reporting system to the relevant ward pharmacist. If further information or follow up was required, the ward pharmacist was contacted to assist with this.
- Staff on all wards were open with patients when things went wrong. For example, one record of a patient on Lavender ward showed that staff had made an error in the management of patient's medicines. This was then reported as an incident and the staff had then arranged for the patient to speak with a doctor about the possible implications of the error.

Good

Are services safe?

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

- Staff the wards received feedback concerning incidents in a variety of ways. Staff held monthly business meetings to discuss patient's cases and any serious incidents. Managers also undertook monthly supervision where they discussed incidents with staff. The Lilacs ward manager also ensured that where a staff member had logged an incident on the system they also received details of any resulting action plans by management. This helped reassure staff members reporting incidents that their actions had resulted in prompt and necessary steps to safeguard patient safety. The ward the manager had also initiated a weekly feedback day where both learning from events as well as positive messages of thanks from patients and their families was passed on to staff. All wards had fortnightly complex case reflection meetings where clinical staff, including psychologists met with ward staff to discuss incidents and the learning from them. Staff confirmed there was a learning culture on the wards and were supported by managers to discuss openly incidents to improve practice.
- There was evidence that staff learned from incidents and took steps to prevent them from happening again. For example, on Lavender ward the ward manager had analysed information on adverse incidents between patients. They identified that incidents had tended to occur in the dining area which had been located in the centre of the ward. Consequently, the staff team had changed the layout of the ward and developed a new, quieter location for the dining area. This has resulted in fewer incidents between patients. In another example on Ward 3 the keys to the medicine cabinet went missing and staff could not trace them. The outcome of the investigation resulted in a change to practice including a signing in and out process for recording who had the keys during a shift. This process also provided an audit trail and staff accountability. On Jupiter ward a patient recently received a double-dose of their medication after a staff member failed to observe from the patient's record that a colleague had already given them the drug. This resulted in immediate additional pharmacy training for all staff members concerning medicines management.
- Staff received debriefs following incidents and psychological support was also available, if staff required it.

Psychiatric Intensive Care Unit (Ward 1)

Safe and clean environment

- The layout of the ward had wide corridors in the communal area allowing for observation to take place. There were blind spots in certain parts but staff took steps to reduce the risks arising from this by always having staff in those locations.
- The seclusion room was compliant with the Mental Health Act code of practice. There were soft furnishings, a toilet, shower and basin, a visible clock, external control of lighting and a fixed temperature control. The office next to the seclusion room had viewing panels for staff to observe patients, including a blind covered panel for the bathroom. Communication between staff and patients in seclusion was through a hatch. A microphone was positioned by the hatch for staff to monitor patients' breathing. There was a blind spot near the door, but staff had installed a mirror to reduce the risk arising from this and planned to install a further viewing panel.
- The seclusion room was used as a last resort after verbal de-escalation. Staff appropriately recorded the use of the seclusion room in the incident log and managers reviewed all incidents to ensure that staff had taken all necessary actions. Staff spoke to patients after seclusion to support them to understand why it was necessary and to answer any questions.
- The ward area and bedrooms were clean and well maintained. The furniture was in good condition and the decoration was bright and clean.
- The clinic room on the ward was clean and tidy with emergency equipment, including grab bags with resuscitation equipment. Medicines were in date. Records showed the staff checked the equipment and medicines regularly. Medicines used in emergencies and resuscitation were available and accessible.
- Emergency ligature cutters were located in the clinical room in the emergency grab bag and in the nurses office and staff knew of their location.
- Staff checked the temperature of fridges every day to ensure they were correct.
- The ward area was clean and well maintained. A cleaning rota for the ward was in place and cleaning records were displayed on the toilet doors. Patients said staff cleaned the ward daily, including their bedrooms and did this to a high standard.
- All staff had personal alarms and were trained in using and responding to an alarm call.

Good

Are services safe?

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

- Staff regularly completed environmental risk assessments on the ward. Where staff identified risks this resulted in an assessment to establish how they would be reduced or removed. For example, staff recognised the power leads from the television in the lounge were a ligature risk due to the length of lead required to reach the socket. To reduce this risk they moved the position of the power socket on the wall so that a much shorter power lead was required.

Safe Staffing

- The ward staffing levels during the day were 4 qualified nurses and 2 healthcare assistants (HCAs) and at night there were 3 qualified nurses and 2 HCAs.
- Staff vacancies between November 2014 to October 2015 were 13%. The trust was undertaking a recruitment campaign to fill all its vacancies. This campaign included visiting university campuses and employment fairs to explain the work of the hospitals and attract new applicants.
- In the last 3 months the ward employed bank and agency staff. 1056 shifts had been covered by bank or agency and 33 shifts reported as unfilled.
- The reported sick rate for the period of November 2014 to October 2015 was 7.5%.
- The manager used an electronic roster system to plan staffing levels so they could book bank or agency staff well in advance. Patients reported seeing regular faces within the staff team, but some reported there was a high number of agency staff used who they did not know.
- Staff said the use of agency staff sometimes caused challenges as agency staff did not have access to the patient record system meaning they could not enter notes on the patient care records or see information including risk relating to the patient. To meet this problem managers looked to fill shifts with bank staff familiar with the wards and patients rather than employ agency staff. As a result, in the past three months bank staff covered 356 shifts and there were no shifts covered by agency staff.
- The ward manager was able to adjust staffing levels to meet the needs of the ward. For example, when patients required close observation managers requested additional staff to undertake the task.
- The ward manager said that all staff had an induction and were supported by a permanent member of staff to become familiar with the ward. Managers monitored staff progress after induction during supervision. Staff said the induction was thorough and they found the support from other staff a positive experience.
- Bank and agency staff who had not worked on the ward before also completed a short induction.
- A qualified nurse was on the ward at all times.
- Staff said there was enough staff on the ward to allow for nurses to undertake 1:1 sessions with patients. Patients confirmed that they regularly had this time with a nurse.
- Patients and staff confirmed cancellation of escorted leave was rare. The ward recently introduced a new system which allowed the use of video conferencing for court appearances to reduce the need for patients to leave the ward. This reduced the number of staff who had to leave the ward and therefore made more staff available on the ward to support the needs of patients.
- There were enough staff members to carry out restraint safely and in accordance with trust policy and national guidelines.
- The ward had one consultant and one doctor and there was out of hours cover for during the night.
- 72% of staff had completed their mandatory training, which was below the trust target of 95%. Managers were addressing the issue via staff meetings and supervision to ensure the target was met.

Assessing and managing risk to patients

- The ward reported they used seclusion 38 times and physical restraint 34 times during a six month period between September 2015 and February 2016. Three of these restraints were in the prone position. Staff reported restraints as incidents and the ward manager reviewed all incidents to ensure that staff had taken all necessary steps in response to them. Records showed that staff used de-escalation techniques to reduce the use of restraint. Staff said physical restraint was used as a last resort and they preferred using de-escalation. Staff discussed coping strategies and behaviour management with patients in order to help reduce the incidence of restraint. Staff recorded these discussions in patients' care plans.
- We looked at nine incident records. Five of these involved seclusion and three of those involved the use of rapid tranquilisation. The incidents had taken place

Good

Are services safe?

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

between January and March 2016. The reports gave detailed descriptions of what had happened, the outcomes and showed that staff had followed policy and procedure.

- Blanket restriction were in place on the ward. These were in response to identified risks, including a ban on patients possessing cigarette lighters and the possession of mobile phones on the ward.
- Staff demonstrated they understood the principles of safeguarding and how to raise safeguarding alerts. Procedures were in place on the ward to ensure staff promptly responded to safeguarding concerns.
- Staff undertook good medicines management including safe storage of medication and the dispensing of drugs to patients. Staff properly stored drugs, including controlled drugs and kept records up to date. A pharmacist regularly came to the ward to check that staff were properly administering and storing drugs and delivered training to staff in response to any issues identified. On admission staff checked with the patients' GPs regarding any current medications they were taking to enable continuity of prescribing.
- Staff monitored patients' physical health every day. Systems were in place to alert staff to any health concerns, such as raised blood pressure, in order to trigger the necessary clinical response.
- Child visitors were not permitted on the ward. A family room was available which had age appropriate toys for young children and the room was clean, well-furnished and had information boards informing visitors of support services and networks available to them.

Track record on safety

- There were 2 serious incidents on the ward in the year prior to the inspection. One concerned a patient who was found unresponsive in the seclusion room and subsequently died and the other the injury of a patient who jumped from a window.

Reporting incidents and learning from when things go wrong

- Staff demonstrated good knowledge of how to report incidents on the ward.
- Staff were provided with feedback from incidents from the trust governance department, during handovers, ward rounds, monthly meetings and they were discussed in supervision. Staff confirmed there was a learning culture on the wards and they were supported by managers to discuss incidents openly to improve practice. Staff and managers confirmed that they would invite the virtual risk team to the ward to review incidents and change practice to implement the learning from incidents. The staff said they found this process helpful.
- Staff and managers said they discussed incidents, where appropriate with patients, in order to be open and honest about what had happened. An example given was when a patient received medication at the wrong time, staff explained to the patient what had happened the impact of the error and gave assurance the patient and relatives.
- After incidents, managers met with staff to discuss what had happened and to identify any points of learning. Support was available for staff from a psychologist if they needed to discuss particularly challenging issues arising from incidents.

Are services effective?

Good

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.

Our findings

Acute wards

Assessment of needs and planning of care

- Staff completed prompt and detailed assessments of patients' needs upon admission.
- Staff conducted an initial physical health check of patients upon admission. Staff also checked the physical health of patients every day by undertaking standard observations such as blood pressure and heart rate. The wards used a national early warning score system to monitor the physical health of patients. This system worked by staff allocating a score to a series of key of physical health measurements such as blood pressure. When a patient's score reached four or above this triggered immediate action from staff such as medical examination of the patient. Staff logged scores which had triggered urgent medical input as incidents. Patients on all wards had access to physical healthcare treatment at local hospitals, if required. For example, a patient on Jupiter ward attended St. George's Hospital for nurses to dress a wound. The trust employed a physical healthcare lead who liaised with all wards to ensure that patients' physical healthcare needs were met. On Wards 2 and 3 at Springfield Hospital we observed good communication in handovers, weekly ward rounds and team meetings regarding patients' physical healthcare needs. Staff and patients on these wards reported good access to other specialists services such as dentists. All wards provided a smoking cessation programme for all patients who wanted it.
- Many care records that we saw were detailed and clearly reflected the patient's wishes. However, eight of the records from Wards 2 and 3 showed only limited patient input.
- Staff stored information securely and this was accessible to most staff. However, some staff on a number of wards said that because agency staff did not always have access to the electronic record system used by the hospitals this could cause occasional difficulties. These arose when agency staff were not able to enter notes about patients on the system, or could not access patient records to look at their care plans or risk assessments. This required regular members of staff to perform those tasks instead. However, there were no reported incidents or records of harm to patients caused by this situation.

Best practice in treatment and care

- Records showed that staff prescribed medication in accordance with national guidelines.
- Staff on all wards were able to refer patients to see a psychologist if they identified a need and psychologists also undertook some group therapy on all of the wards. However, there was not a dedicated psychologist for each of the wards. There was psychology support for staff on all wards. Staff groups met with a psychologist every week to reflect on complex cases. Psychology support was also available for staff on a 1:1 basis to help them after dealing with challenging incidents. Staff on many wards spoke positively about the psychology support for staff. However, several staff members across all the wards expressed concern that there was insufficient psychology support for patients to deliver the psychological interventions in line with national institute for health and care excellence guidance.
- A dietician visited the wards weekly to advise staff about supporting patients in relation to their nutritional requirements. For example, a dietician met with a patient on Rose ward and their family to plan how their nutritional needs could be met so that it met the dietary requirements of the patient's faith and physical health.
- Staff on all wards used a recognised tool in order to measure how well patients' health was improving during their stay in hospital. The tool was the health of the nation outcome scales. The tool requires staff to regularly rate patients' health in relation to 12 key indicators.
- Staff on all wards actively participated in clinical audits including safe storage of medication and environmental audits. Staff were also given individual lead roles to enable them to take ownership of an area and develop their skills in auditing.

Skilled staff to deliver care

- All of the wards had input from a wide range of professionals, including nurses, psychiatrists, occupational therapists and activity co-coordinators. Psychology sessions were available to the wards. Each ward had a discharge co-ordinator who liaised with the patient's social services team.

Are services effective?

Good

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.

- All staff were suitably experienced and qualified to support the care and treatment of patients.
- Managers on all wards admitted that they had not always been able to achieve consistent levels of staff supervision. However, managers had recently given greater attention to this task and records on all wards showed that staff were receiving monthly managerial supervision. Staff on all wards also received clinical group supervision once a week. There were regular meetings for staff to discuss their work and patients' cases. We looked at 39 staff supervision records. These were detailed and showed that managers supported staff to raise a range of issues.
- Staff on all wards received the necessary specialist training to undertake their duties.
- We asked ward managers how issues of poor staff performance were dealt with. They told us they received support from their managers and the human resources department in relation to any issues about staff competence.

Multi-disciplinary and inter-agency team work

- We attended eight multidisciplinary team meetings across the wards. All were well organised with a clear focus on the recovery and discharge of the patient. All members of the staff team were able to give their input. Clear decisions were made and recorded.
- We observed five handover meetings across the wards. These were well organised and covered a range of patient matters, including risks, physical health, medication, activities, leave and discharge. Staff discussed how new patients on wards were settling in as well as how plans for patients ready for discharge were progressing. In addition to nursing staff and clinicians, occupational therapists also attended handovers. This allowed for a full exchange of information on a variety of subjects, including how patients were managing with their medication and their attendance at activities.
- Staff on all wards had developed good links with external agencies to help support patients' discharge. For example, staff worked with housing providers to ensure appropriate accommodation was available for patients upon discharge. Benefit advisors from external agencies also came to the wards to support patients with welfare claims.

Adherence to the MHA and the MHA Code of Practice

- Most staff on the wards had completed training in the MHA and Codes of Practice, although this training was not mandatory. On all wards the completion rate for training in the MHA and code of practice was at least 80%. On Ward 3 the completion rate was 100%. Staff demonstrated a good understanding of the Act and the codes of practice. All wards also had a trained MHA officer, who was a senior nurse responsible for handling MHA matters.
- On all wards staff had completed assessments of patients' capacity to consent to treatment and in most cases staff had attached patients' consent to treatment forms to their medicine charts. However, on Lilacs ward patients' consent to treatment records were not attached to their treatment charts. Staff explained that these forms were currently being reviewed by colleagues in the Mental Health Act office and would be returned.
- Most records showed that staff explained to patients their rights under the Mental Health Act, both upon admission as well as at intervals post admission to ensure that patients understood them. However, on Lavender ward one patient's record showed that staff had attempted twice to explain a patient their rights, but the first time the patient did understand and on the second they refused to listen. But the staff did not make any further attempts to explain the patient their rights for another four weeks and then this only took place when the patient requested the information themselves. There were also two examples of staff not properly discharging their legal duty to explain patients' rights to them on Lilacs ward. Firstly, records showed that staff had not informed a patient of their rights until three weeks after their admission. In the second case staff on the ward had tried to explain to a patient their rights on two occasions, but the patient was either too unwell or refused to listen. However the staff did not then record a further attempt for another two weeks. The law requires that staff inform detained patients of their legal rights 'as soon as practicable' and the code of practice requires that staff repeat this information at further intervals after detention. Failure to ensure that patients properly understand their legal rights when detained also creates a risk that a patient will miss the opportunity to appeal

Are services effective?

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their detention. This is because when detained in hospital for staff to assess their mental health patients only have up to two weeks to appeal their detention to a tribunal.

- Staff on all wards correctly completed the paperwork in relation to each patients' detention and they stored it securely.
- Staff working in the Mental Health Act offices responsible for supporting the work of the wards audited the records of detained patients regularly and made recommendations for action when necessary. MHA staff also provided advice and guidance to staff.
- Patients on all wards had access to an independent advocacy service to help them raise issues in relation to their care and treatment. Advocates regularly visited the wards to meet with patients and staff referred patients to the service where they identified that patients would benefit from advocacy.

Good practice in applying the MCA

- Across all acute wards staff completion of mandatory MCA training as part of the training on consent was over 80%.
- Staff on all wards were able to demonstrate a good understanding of the main principles of the act.
- In the past six months prior to inspection staff had not made any applications for authorisations of Deprivation of Liberty Safeguards.
- The trust had a policy in respect of the MCA and this was available to all staff.
- Where patients potentially had impaired mental capacity to make specific decisions, staff assessed their capacity to determine whether they could make that decision. Staff mostly completed these records correctly. However, on Lilacs ward staff completed a capacity assessment for the patient upon admission, but when staff later changed this decision there was no explanation at all of the basis for this decision.
- The records showed that staff supported patients to reach decisions and where a patient lacked capacity staff took decisions in patients' best interests. For example, the multidisciplinary team on Rose ward had organised a 'best interests' meeting to make decisions in relation to a patient's physical health needs when they lacked the mental capacity to make this decision them self.
- Advice and guidance regarding the act was available for all staff from the Mental Health Act office.

Psychiatric Intensive Care Unit

Assessment of needs and planning of care

- The 6 records we reviewed showed staff undertook physical and mental health assessments on admission and regularly updated these. Every patient had their physical health observations checked in the morning. Any changes would be raised by staff with a doctor so that appropriate action could be taken.
- Staff completed care records on admission. The six records we examined showed minimal input from the patient. However, the case notes for 3 patients were detailed and stated how the staff planned to support the patient during the recovery process.
- Staff on the wards securely stored information concerning patients and this was accessible to most staff on the wards. However, agency staff were not able to access patient electronic records. Where an agency staff member required information regarding a patient this had to be obtained by a colleague with access to the electronic system.

Best practice in treatment and care

- The administration of medicines was safe, effective and evidence based according to national guidelines and in accordance with trust policy.
- Patient access to support from a hospital psychologist was limited to one session per week while on the ward. However, the community psychologists also visited patients on the ward which provided additional support.
- Staff undertook a full physical examination of patients on admission and monitored the physical health of patients on a daily basis. We observed good communication between staff in handovers, weekly ward rounds and MDTs which covered the physical needs of patients. Staff and patients reported good access to other specialist services such as dentists. One patient confirmed a planned operation went ahead whilst they were a patient on the ward. The hospital provided smoking cessation programme for all patients who wanted it.
- Clinical staff participated in a range of clinical audits including the safe storage of medication and environmental audits. Staff were also given individual responsibility for undertaking audits to enable them to take ownership of an area and develop their skills in auditing.

Are services effective?

Good

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.

Skilled staff to deliver care

- A range of professionals were available to support patients on each ward. This included nurses, occupational therapists, doctors and activity co-ordinators.
- Staff were suitably experienced and qualified to support the care and treatment of patient care.
- All staff received an induction, which included observation of their practice and mandatory training.
- Managers said that they had not always been able to provide frequent supervision for staff, but in the last three months they had been able to do this monthly. The records viewed showed supervision was detailed and supported staff with a range of issues and individual staff member's involvement was recorded. Staff reported they had support on clinical and managerial issues from various forums and meetings. Staff records included copies of staff appraisals and reviews.
- Staff were experienced in working on mental health wards and received specialist training to support them in performing their duties.
- Staff records showed managers took appropriate action to manage poor performance and sickness.

Multi-disciplinary and inter-agency team work

- Meetings of multidisciplinary teams took place regularly and discussed patient care and discharge planning.
- We attended a handover meeting on the ward. The handover was well organised and covered a range of areas including risks, physical health, medication, activities, leave and details of each persons MHA status. Staff followed and completed a check list to ensure that the handover covered all necessary matters.

Adherence to the MHA and the MHA Code of Practice

- The completion rate on the ward for Mental Health Act (MHA) training was 100%.
- Staff on the ward demonstrated their knowledge of the rights of detained patients.
- Staff said patients had their rights under the MHA explained to them on admissions and weekly during their stay. Patients confirmed this. Staff obtained interpreters using a trust booking system if patients required help understanding their rights.
- Staff received advice and guidance from the Mental Health Act office in the hospital regarding the law and codes of practice.
- Staff appropriately completed and stored patients' detention paperwork.
- Patients detained under the MHA received medicines in line with the MHA code of practice. Where required staff completed consent or authorisation certificates and attached them to the patients' medicines charts.
- The ward had weekly visits from independent advocacy services to support patients raise issues concerning their care and treatment. The ward notice board gave details of the advocacy services and displayed information regarding patients' legal rights.

Good practice in applying the MCA

- Staff we spoke to were able to demonstrate knowledge on the principles of the MCA. For example a member of staff described the process she used when assessing the needs of an elder patient who was showing signs of dementia.
- The trust had a policy relating to the MCA which was available on the trust intranet.
- The MHA office provided support and guidance for staff on matters concerning MCA

Good

Are services caring?

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

Our findings

Acute Wards

Kindness, dignity, respect and support

- The interactions we observed between patients and staff on most wards were supportive and staff treated the patients with compassion. Staff generally had a good rapport with patients and showed care and empathy. Many of the patients we spoke to confirmed this. On Laurel, Lavender and Rose wards the inspection team observed that staff interacted in a friendly way with patients. Staff spent time in the communal areas of the wards and took the initiative in talking to patients by asking them how they were and if there was anything they could do for them. On Lilacs and Jupiter wards we observed staff being attentive to patients' requests and concerns raised by patients. However, we also observed on Jupiter ward some patients sitting or walking around alone for long periods without any engagement from staff. In addition one inspector witnessed a senior member of ward staff raising their voice to a patient and speaking to them rudely.
- Generally patients on all wards reported that staff treated them with respect and kindness. For example, patients on Lavender and Rose wards commented that staff showed respect by always knocking on their doors before entering. A patient on Lavender ward also complimented the manager saying they had been very supportive. Patients on Lilacs ward also spoke positively. One described the service they received from staff as 'priceless' while another said had helped them overcome thoughts of self-harm and had been 'excellent.' Patients on Jupiter were also generally positive about how staff treated them. However, several patients across Lavender, Rose, Laurel and Jupiter wards also commented that staff always seemed to be busy when they wanted to speak to them. Some patients on Wards 2 and 3 also said that staff were not always respectful and did not knock before entering their rooms.
- Staff generally demonstrated a good understanding of patients' needs and how to meet them. For example, a health care assistant on Rose ward was able to tell us what was important to a patient they were responsible for in terms of their daily routine, about their family relationships and discharge plan. Also, where staff on Jupiter and Lilacs wards identified that a patient had a learning difficulty (LD) they immediately contacted the local adult LD team at the local authority to ensure that the patients' needs would be supported on discharge.

The involvement of people in the care they receive

- All patients received a welcome pack on admission, which included information regarding the services in the hospital, patient rights, advocacy and how the wards operated.
- Most patients that we spoke to said they had received a copy of their care plan. Many confirmed that they had discussed their care plan with staff and also that family members were involved in their care and treatment. Some wards also had meetings dedicated to supporting the involvement of families and carers. This included a weekly session on the Laurels ward between the psychiatrist and patients' families. On Lavender ward there was a carers recovery worker funded by Richmond health and social services. The worker's role was to ensure there was effective communication between families and carers and the multidisciplinary team in relation to the patient's treatment and discharge. Records also showed that pharmacists regularly met with patients to discuss their medication, side effects and what treatment options were available. We looked at 45 care plans across all the wards and most recorded the wishes and preferences of patients. For example, several of the care plans we saw on Jupiter ward detailed patients' goals upon discharge and how staff were to support these goals.
- Patients on all wards had access to an independent mental health advocate (IMHA). IMHAs on all wards supported patients to raise a variety of issues, including requesting leave, asking for a ward transfer, changing medication and support to make complaints. All wards displayed information detailing how patients could contact the advocacy service, who the IMHA on the ward was and which day they visited.
- Every ward held a weekly community meeting for patients to attend with staff in order to raise any issues relating to the ward. We observed six meetings. During them we saw that staff listened respectfully to patients' concerns, ideas and suggestions and gave support and responded with commitments to action. Staff encouraged patients to speak about how wards were run, as well as listen to each other. The issues that

Good

Are services caring?

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

patients raised included requesting Caribbean food at mealtimes and what courses were available for them to do in the trust's recovery college. On Rose ward, we attended a community meeting and observed how issues which had been raised by patients, for example about the cleaning of the ward, were followed up.

- In addition to the community meetings there were systems for patients to give feedback about the service. For example on the wards in Queen Mary's hospital we saw patients using a computer based system to give real time feedback on their experiences. This information was collected centrally and the trust and also sent to ward managers so they could make an immediate response.

Psychiatric Intensive Care Unit

Kindness, dignity, respect and support

- We saw good interaction between staff and patients on the ward and staff took the time to engage in conversation with patients.
- Patients said most of the staff were caring and the atmosphere was relaxed.
- Staff demonstrated a good understanding of the patients' individual needs. Patients said the staff supported them to involve themselves in activities and community meetings.

The involvement of people in the care they receive

- We spoke with five patients, four said they were involved in the planning of their care and had copies of their care plans. However, two of those patients said the care plans did not detail anything about their medication. Some patients said that their relatives and carers were involved in the planning of their care.
- Staff reported the care plans on admission tend to be prescriptive and become more focussed on recovery as the patients mental health improves.
- Some patients said they had raised physical health issues during the daily health checks by staff and that they felt staff listened to and responded to their concerns.

Are services responsive to people's needs?

Good

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

Our findings

Acute Wards

Access and discharge

- The average bed occupancy across the acute wards in a six month period between June 2015 and November 2015 was 111%. The ward with the highest occupancy rate during that period was Ward 2 at 129%. The lowest was Lavender at 103%. The percentages were greater than 100% because all wards had more patients than beds. This was because some patients on those wards were on leave.
- The trust was taking steps to manage the challenge of having more patients than beds. The admissions to the acute beds across the trust were co-ordinated by an acute care co-ordination centre (ACCC). This service operated 24 hours a day and was located at Springfield Hospital. The service was staffed by qualified nurses who understood the needs of the patients. When staff from the home treatment teams identified that there was a clinical need to admit a patient they would liaise with the ACCC. The ACCC maintained an updated record of the beds available across the trust. They would identify the most suitable service for the patient and if needed they could arrange a bed in the independent sector. All the wards reported that the support of the ACCC had made the admission process for patients much smoother. The staff from the ACCC also provided out of hours emergency support to the ward staff on the Springfield site and provided guidance and support to staff working on the crisis line. Other steps taken by the trust to meet the need for beds also included the opening of a new acute ward in April 2016 to help provide additional capacity. In addition, the street triage undertaken by staff in partnership with the police was helping to manage the needs of patients in crisis. This directed patients to the most appropriate services and had helped to reduce admissions and therefore the need for beds.
- The catchment area for the trust was across the five London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. Staff managed admissions so that beds were available across the catchment area for patients living in that area.
- When patients returned from leave in the community the bed they previously occupied was not always available. This was due to bed pressures across the trust. When this happened a bed was found for the patient on another ward or on the same ward but a different room. However, because patients usually did not go on home leave overnight they mostly did not lose their beds on the ward.
- Staff rarely moved patients between the wards after admission unless this was for clinical reasons. Also as the catchment area of the trust was large covering several boroughs patients from that area could be admitted to a service that was some distance from their home. Therefore, if a patient asked to move to a different service closer to their home after admission and staff identified that it was in the patient's best interests to move them to an available bed then they did this.
- Staff planned the discharge of patients many weeks in advance, in coordination with other services such as home treatment teams. This meant that staff were able to move patients at an appropriate time of day.
- Where required, a bed on a psychiatric intensive care unit (PICU) was available in the trust for male patients on Ward 1 at Springfield hospital. This was normally available the same day or the next day. For example, on the day of the inspection, a patient on Laurels ward moved to the PICU following an incident which had occurred the previous night. Where a female patient required a PICU bed, the trust had commissioned two beds on Shannon ward at St Charles Hospital. In addition to this resource the trust spot purchased female PICU beds. Due to the demand for these services across London there was sometimes a delay in finding a bed. Staff managed these delays keeping unwell patients under close observation until a bed was available.
- Discharge coordinators worked on each acute ward to help plan the discharge of patients. They did this by liaising with ward staff and other services such as home treatment teams and local authorities to identify which patients were ready for discharge and what services they would require in the community. This meant that patient discharges from the wards usually took place in a timely way. Sometimes a patient's discharge was delayed. During a six month period between May and October 2015 the highest number of delayed discharges from acute wards was on Lavender ward were 18 were delayed. Three wards shared the lowest number of

Are services responsive to people's needs?

Good

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

delays, with Laurel, Rose and Ward 2 having two each. Many delays occurred for non-clinical reasons, usually because of the challenge of finding appropriate housing for patients returning to the community.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had an appropriate range of rooms to support patients' needs. The clinic rooms on each ward were clean and spacious. There were other rooms that could be used for group work and patient activities. Wards had quiet rooms and rooms where they could have private meetings with their families, carers and advocates. On mixed sex wards separate facilities such as bathrooms and laundry rooms were available. However, not all facilities promoted patient dignity and privacy. On Lavender ward there were panels set into bedroom doors to allow staff to observe patients in their rooms. But patients were unable to open or close the panels from inside and some panels had been left open, potentially compromising patients' privacy. This contrasted with the other acute wards were patients were able to close the same panels on their doors. On Jupiter ward patients complained individually and during their community meeting that there was a gap between the door and the wall on both male and female toilets. We inspected these facilities and saw that a gap of approximately a centimetre existed between the door and the wall. When asked staff explained that this gap was necessary to permit the doors, which were thick, to close. However, these gaps made it possible when standing close to see into part of each toilet compromising the privacy of patients.
- Patients on each ward were able to make private calls from their own phones. Where patients did not have a mobile phone they were able to make calls privately from phones on the ward.
- Patients on all wards had access to outside areas. These included smoking areas. On Wards 2 and 3 and Lilacs ward patients also had areas for gardening and growing vegetables.
- Patients generally said that the food was of reasonable quality.
- There were areas on all wards where patients could make drinks at all times of the day.
- Patients were able to personalise their bedrooms, including putting up pictures and bringing items from home.
- Most patients could lock their bedrooms, although patients on Lilacs and Jupiter wards did not have their own keys and had to ask staff to lock their rooms. All patients' rooms had their own safe for patients to securely store property.
- There was a wide range of activities available to most patients throughout the week and at weekends. These included cooking, art therapy, gardening, computer skills, relaxation, life skills and goal setting groups. On Lavender ward we attended a patient group meeting led by the occupational therapist. A representative of the trust's patient recovery college attended the meeting to explain to patients what was on offer to them. We observed an activities coordinator on Laurel ward supporting patients to go out of the ward to play tennis. Patients were generally positive about the range of activities available to them. However, patients on Lilacs ward expressed unhappiness that there were no activities available at weekends. Activities also did not always go ahead because of staff absence. For example, on Jupiter ward on the day of our visit notice boards showed that staff had cancelled many activities because of the absence of the activities coordinator.

Meeting the needs of all people who use the service

- All wards had level access and were suitable for wheelchair users, including having specific bedrooms and toilets for those in wheelchairs. The trust had also undertaken a recent disability audit to ensure that all buildings were accessible for wheelchair users.
- Leaflets were available on the wards regarding local services. However, none of these were in languages other than English. All wards had access to interpreter services using a trust-wide booking system.
- All wards displayed a variety of detailed information, including on patients' legal rights, independent advocacy services, medicines and how to make a complaint.
- The daily menus in each of the patient dining areas on the wards showed that a variety of food was available, including vegetarian options and for those with food allergies, such as gluten-free meals. Information was displayed about healthy eating. Patients from ethnic and religious groups were able to order food to meet their dietary needs.

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 able to access spiritual support of their choice. Religious leaders visited the wards on a regular basis and patients could also make their own arrangements to follow their spiritual beliefs.

Listening to and learning from concerns and complaints

- Over a 12 month period from December 2014 to November 2015 patients had made 109 complaints regarding the acute wards. After an investigation staff had fully upheld six of these complaints and partially upheld 27. During that period one complaint was referred to the health ombudsman, but this was not upheld. Complaints concerned a variety of different issues. There were no specific themes apart from several complaints regarding the lack of available food choices on the wards.
- Most patients told us they knew how to make a complaint and those who had made complaints had received feedback from staff. Additionally, a member of the trust's patient experience team visited the ward each week to talk to patients to ask if they had any complaints. Patients on the wards were also able to give feedback given through a 'real time feedback' system. This allowed for patients to immediately record any concerns and these were immediately sent to ward managers.
- Patients' records demonstrated that staff across the wards knew how to respond to patients' complaints and did so in a timely and appropriate manner.

There was evidence that staff responded to issues raised by patients. For example, on Lavender ward patients had requested additional condiments and sauces to have with their meals. In response the ward manager had organised funds to enable patients to purchase a range of products of their choice.

Psychiatric Intensive Care Unit

Access and discharge

- Between June 2015 and November 2015 the average bed occupancy was 92%.
- The average length of stay for patients on the ward between December 2014 and November 2015 was 26 days and for patients at the time of our inspection was 38 days.

The facilities promote recovery, comfort, dignity and confidentiality

- Ward 1 had a communal dining room, laundry, activity room and lounge and quiet rooms. There was a large fully enclosed outside area where patients could play ball games including basketball and a smoking area. Staff supervised all patients when outside to reduce the risk of harm as there were blind spots in the outside area.
- Patients had access to a range of activities including gym, a computer with restricted internet access, and a media group.
- The ward was decorated and furnished to a good standard and was bright and airy.
- Patients could make private calls using a ward phone.
- Patients were allowed to personalise their bedrooms including bringing their own bedding.
- Patients were able to close the observation window on the door to their bedroom to allow for privacy.
- Staff provided hot drinks every hour and we observed a tea trolley being used on the ward to distribute the drinks.
- The seclusion unit supported patient privacy by having an observation window in the door that the patient close from the inside to prevent anyone looking in. Staff were also able to open this window from the outside to check on the safety of patients. The observation area used for watching people in seclusion allowed for the patient to use the toilet and shower without observation subject to being risk assessed. Nurses monitored patients' breathing when they were asleep through an intercom system.

Meeting the needs of all people who use the service

- The bedrooms were all en-suite and the ward had wheelchair accessible bedroom.
- The patients reported there was a varied choice of food available to them which catered for religious and dietary needs. They pre-ordered meals from the menus displayed on a notice board. Patients said the food was good and they enjoyed mealtimes.
- Patients had access to spiritual support from a range of faiths. The ward manager said they had invited a local imam to the unit to speak to the Muslim patients on taking medication during Ramadan.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Good

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

- The ward received 7 complaints in the period from November 2014 to December 2015 and 63 compliments in the same period. The most common complaints related to patients unhappiness at the restriction on the number of times they were permitted a smoking break and in relation to the available choice of food.
- Staff tried to resolve complaints locally on the ward. Patients had the opportunity to use a real time feedback console which the ward manager reviewed and responded to daily. Staff said they support patient to make a formal complaint and where appropriate use PALS.

Are services well-led?

Good

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

Our findings

Acute Wards

Vision and values

- The trust's vision and values were displayed on notice boards and staff said they felt the values were important as the patient care was at the centre of the values. They explained how these values underpinned their work. For example, staff told us how they aimed to promote patients' recovery by working in partnership with their colleagues, the patient and their support network.
- Staff on all wards said they knew who the senior managers were in the trust and these managers had visited the wards. Ward managers said that the modern matrons and clinical services manager were also frequently on the wards and provided important support.

Good governance

- The governance for all wards was effective. Staff had received appropriate training and training levels were appropriately monitored. Training was also continuously provided in specialist areas by pharmacists and psychologists. Staff received regular supervision. Staffing levels on the wards were maintained despite vacancies for permanent staff and any staff shortages had a low impact on patients' care, treatment and recovery. Only on Jupiter ward did a number of patients comment that they did not have enough 1:1 time with nurses. Generally, we observed that staff spent time on direct work with patients rather than on administrative tasks. There was clear evidence that staff knew how to report incidents and that the reporting system was robust and well supervised by ward managers. Staff learnt from incidents and there was a commitment among all staff to understand why things had gone wrong in order to improve patient care. Arrangements for patients to give feedback on the quality of their experience were well-developed. Staff used this information to develop improvements to the service in partnership with patients.
- Staff produced information at a ward level relating to key performance indicators (KPIs). The purpose of this information was to determine whether managers needed to take action in response to those KPIs. For example, staff recorded data in respect of the monitoring and management of patients' physical health to confirm that they were meeting the trust's standards. Each ward displayed the KPI's for staff, patients and visitors to read. Managers discussed the information collected about performance of the wards with staff at formal meetings. Sometimes data showed that ward managers needed to take action. For example, data collected on the wards showed the number of supervision sessions undertaken were not meeting trust targets. Therefore, all ward managers responded by ensuring supervision was undertaken in line with policy.
- Ward managers told us they had sufficient authority to make changes and improvements and that they had effective administrative support. For example, the ward manager of Lilacs ward had introduced 'feedback Fridays' whose principal objective was to inform nursing and clinical staff of positive feedback received from patients. Staff on the ward said they valued this information as it reminded them of the important outcomes for patients' lives their work achieved.
- Information for the trust risk register was collected by ward managers who sent it to senior staff to add to the register.

Leadership, morale and staff engagement

- Staff sickness and absence rates were relatively low across most wards. The rate for sickness, however, was higher on Ward 2 at 10% for the 12 months from November 2014 to October 2015. In response to this the manager of the ward implemented an action plan that has resulted in fewer staff absences. No data was available to confirm how far the rate of absences has dropped, but staff confirmed the working environment on the ward has improved.
- There was no evidence of any bullying or harassment cases happening on any of the wards.
- Staff across the wards told us they understood the trust's whistleblowing process. They said they felt there was an open culture in the organisation and they could easily raise concerns.
- The morale on all wards was generally high. Staff spoke repeatedly about how their managers worked hard to support them and to improve the working environment for all. Staff also said that nursing and clinical teams were mutually supportive and that this made for a positive spirit in the workplace and an environment

Are services well-led?

Good

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.

where teams worked together to help patients recover. It was clear that many ward managers wanted not only to support their staff but to act as role models and to lead by example.

- Staff gave examples of where they had received a positive response to their requests to support and development. On Ward 3 a staff member had asked to train as an occupational therapist and their manager supported this. On Jupiter ward a staff member said they were very pleased when the ward manager immediately approved their request for an extra computer on the ward to help staff with their online training. A newly qualified nurse on Ward 3 spoke positively saying that the support they had received from colleagues in developing their knowledge and skills exceeded their expectations. The trust also ensured leadership skills were developed. For example, the ward manager on Lavender told us that they and the ward consultant had attended a course on leading through partnership.
- Staff demonstrated that they were open with patients went things went wrong.
- Monthly business meetings were held on all the wards. The minutes of these meetings showed staff contributed their views on the operation of the ward and made decisions about how to implement improvements.

Commitment to quality improvement and innovation

- On each ward there were examples of how staff had developed the service. For example, on Rose ward, the manager supported a nurse to develop a new way of working with patients diagnosed with a personality disorder. On Lilacs ward the manger supported a staff member to improve their understanding of the Mental Capacity Act. Having done so the staff member then designed new learning materials for staff on the act that were now used on all wards.

Psychiatric Intensive Care Unit

Vision and values

- Staff said they knew and agreed with the trust's vision and values.
- Staff said they knew the senior staff team and they would visit the ward.

Good governance

- The trust produced information in the form of dashboards at ward level relating to key performance indicators (KPIs). Each ward displayed the KPIs and managers discussed performance at ward and clinical meetings and took appropriate action to improve performance.
- Staff discuss incidents and the learning from them at clinical and staff meetings. For example after an incident in the seclusion unit staff made changes to the unit to provide clear observation in all areas.

Leadership, morale and staff engagement

- Sickness and absence rates are monitored at trust and ward level. Between November 2014 and October 2015 the rates for the ward was 6.6%. The ward manager monitored sickness and this was evidenced in supervision notes.
- There were no reported cases of bullying or harassment.
- The joint leadership displayed by the consultant psychiatrist and the ward manager was effective in the management of the ward. Staff said the approach made the ward feel safe, well managed and offered clear direction for the team.
- Staff reported they felt fully supported by the ward manager and the consultant psychiatrist and were able to be open and honest in giving feedback and suggesting changes in working practice.
- The staff said they valued how the team worked well together and were all supportive of each other. Staff said they had a great respect for the ward manager.
- There was evidence of staff being open and honest and transparent with patients when things go wrong. For example, a patient and their family were informed of an error in dispensing patients' medication. Under the duty of candour responsibilities they discussed the full implications with the patient and family and the learning was passed on to the staff.

Commitment to quality improvement and innovation

- The consultant psychiatrist wrote policies for the trust and ensured the learning from new policies were shared with staff.