

South London and Maudsley NHS Foundation Trust

Other specialist services

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)
RV505	The Bethlem Royal Hospital	National Psychosis Unit/Fitzmary 2	BR3 3BX

This report describes our judgement of the quality of care provided within this core service by South London and Maudsley NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by South London and Maudsley NHS Foundation Trust and these are brought together to inform our overall judgement of South London and Maudsley NHS Foundation Trust.

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask about the service and what we found	4
Information about the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider's services say	5
Areas for improvement	6

Detailed findings from this inspection

Locations inspected	7
Mental Health Act responsibilities	7
Findings by our five questions	8

Summary of findings

Overall summary

Since the last inspection of the ward in March 2015 a number of developments had taken place to improve the safety for patients on Fitzmary 2. A refurbishment programme was underway that was replacing some fittings which could be used as ligature anchor points. Also the environment was improving with bathroom facilities being refurbished. Comprehensive risk assessments were being completed when patients were admitted to the ward. Staff had a good understanding of safeguarding procedures and who to contact when they needed to make an alert.

However, there were still some areas where improvements should continue to take place. This included ensuring observations took place as needed and were recorded, keeping risk assessments up to date and ensuring temporary staff working on the ward had a local induction.

Summary of findings

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

Are services safe?

The ward had made significant progress in terms of improving the safety for patients. This included improvements to the environment, safeguarding processes and risk assessments.

However, the trust should ensure that these improvements are fully embedded to maintain safety going forward.

Summary of findings

Information about the service

The National Psychosis Unit is located on Fitzmary 2 ward at the Bethlem Royal Hospital. The unit has 23 mixed gender beds. The unit receives referrals from across the country and also abroad, for people aged 18 and over who were suffering from treatment resistant psychosis who had received treatment elsewhere and where progress had proven difficult.

The last inspection in March 2015 had resulted in requirement notices in three areas. There were concerns about the quality of risk assessments, staff understanding of safeguarding and the way this was implemented and the ward environment. We followed up these outstanding actions during this inspection visit. Some refurbishment had taken place and work had been done on Fitzmary 2 to address the specific issues raised.

Our inspection team

The team that inspected the National Psychosis Unit (Fitzmary 2) consisted of 1 CQC inspector, 1 Mental Health Act reviewer, 1 nurse, 1 consultant psychiatrist, 1 experts by experience and 1 social worker.

Why we carried out this inspection

This was a focused inspection that was following up on non-compliance identified at the previous inspection.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following question:

- Is it safe?

During this inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 4 patients who were using the service
- spoke with the manager of the ward
- spoke with other staff members including the lead consultant psychiatrist and lead psychologist
- looked at 11 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

During our inspection we spoke with patients. The feedback we received was positive. Patients said they

valued the service and the support they received from staff. They felt well informed about their care and treatment. They were positive about the psychological therapies and therapeutic activities available.

Summary of findings

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should ensure that where patients are being observed that this is recorded correctly.
- The trust should ensure the ligature risk assessment covers all areas of the ward used by patients.
- The trust should ensure that the door to the women's bedroom area of the ward is kept secured when needed.
- The trust should ensure that all temporary staff working on the ward receive a timely local induction.
- The trust should ensure that the ongoing refurbishment work includes the redecoration of the communal lounge.
- The trust should ensure that risk assessments are kept updated as new potential risks are identified.
- The trust should ensure that where a safeguarding alert is made, that the patient records are kept up to date to ensure any actions identified as part of that process are followed through.

South London and Maudsley NHS Foundation Trust

Other specialist services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
National Psychosis Unit/Fitzmary 2	The Bethlem Royal Hospital

Mental Health Act responsibilities

This ward had a visit from a Mental Health Act reviewer as part of the inspection.

This found that the Mental Health Act was generally well managed on the ward. There was scope to further improve the involvement of patients in their care planning. Also the statements of capacity did not include details of how the assessor had reached their conclusion.

Other areas for improvement included the assessment of ligature risks, recording of safeguarding, and updating risk assessments.

Are services safe?

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

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

Our findings

Safe and clean environment

- On Fitzmary 2 the layout of the ward meant there were not clear lines of sight. The trust managed this by regular observations which took place at least once an hour. However, on Fitzmary 2 we saw that two observation records of patients on enhanced observation were not completed. This meant we could not be assured that these checks were taking place as needed.
- Fitzmary 2 had a number of ligature risks which were identified in a ward-specific assessment and staff were aware of these. Extensive work was ongoing to replace fixtures and fittings such as door handles and taps to reduce ligature points. Together with individual patient observations, this served to mitigate most risks. The ligature risk assessment which covered Fitzmary 2 did not contain information about how risks in the dining room had been reviewed and considered. This meant the ward was making significant progress in the management of risks from ligature points, although the risk assessment needed some further consideration.
- Fitzmary 2 was a mixed gender ward. The ward was separated into distinct male and female bedroom areas and single sex lounges. The female area was accessed through a door with a security code system. We were told that female patients were given the code and it was changed regularly. We did observe while we were on the ward that this coded door had been left open.
- Wards had fully equipped clinic rooms. Staff ensured emergency equipment was in place and was regularly checked. There were records to confirm these checks took place. On Fitzmary 2, two airways were missing, although they had been ordered.
- The ward was clean. There were appropriate furnishings. Since the last inspection refurbishment was taking place to improve the safety and suitability of the facilities. The bathrooms were being refurbished and the clinic room was complete. We observed damage to the ceiling and wall in the communal lounge which had been noted in the last inspection in March 2015. This did not have a

date for repair. This meant there was significant progress with the refurbishment of the ward, although the communal lounge still needed a clear timescale for redecoration.

Safe staffing

- During the day there were three qualified and two unqualified nurses on duty and at night this reduced to two qualified and two unqualified nurses. Additional staff could be arranged for patients who need higher levels of support.
- Wards had specific induction processes for bank staff including orientation to the ward and general housekeeping. On the day of our visit, at the Royal Bethlem Hospital, we had concerns about the competence of one agency member of staff on Fitzmary 2 with regards to their observations of patients. We asked to view the local induction paperwork relevant to this person. It had not been completed.

Assessing and managing risk to patients and staff

- Records showed that staff carried out individual patient risk assessments when patients were admitted. These risk assessments were regularly reviewed. We reviewed three patient records and found that incidents had occurred relating to risk in the past three months, been detailed in the case records and had not been updated in the risk assessment information. This meant that there had been progress with the completion of comprehensive risk assessments on admission, but further work was now needed to keep risk assessments up to date.
- Staff had a good understanding of safeguarding procedures and knew how to access support when necessary. Fitzmary 2 had developed a tracking system since our last visit in March 2015. Posters and flowcharts, guiding staff in making referrals were displayed around the ward. We saw ten records included on the tracking system, eight of which were current. However, only four of these had included safeguarding plans. One patient's records showed that there were 'no active safeguarding issues' despite a safeguarding referral being made the week before. This meant that ward staff now had a good understanding of safeguarding and were making alerts

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where needed. Whilst the ward had developed a tracking system, the records for individual patients were

not always up to date. This meant it was not possible to always know the outcomes of the alerts. This could result in staff not supporting patients in line with the findings from safeguarding processes.