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

Queen Mary's Hospital

Quality Report

Roehampton Lane
Roehampton
London
SW15 5PN
Tel: 020 8487 6000
Website: www.swlstg-tr.nhs.uk/

Date of publication: 06/12/2014
Date of inspection visit: 17-21 March 2014

This report describes our judgement of the quality of care at this location. It 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.

Summary of findings

Contents

Summary of findings

Overall summary

Queen Mary's Hospital is in Roehampton, and South West London and St George's Mental Health NHS Trust provides the three inpatient wards that we visited as part of this inspection.

We found that the services were safe, the wards were clean and staff were aware of risks. There were ways to report and learn from incidents, but improvements were needed in assessing and managing risks to people's safety.

Staff interacted with people who used the service in caring and compassionate . People and their relatives were involved in planning their care, although records did not always reflect this. People were engaged in activities they felt were meaningful and therapeutic. Ward staff listened to people's feedback and involved them in making positive changes.

Staff often did not have direct access to specialist training. However, they responded to people's needs by engaging other services and working in collaboration with specialist teams.

The hospital worked well with the general hospital (which is on the same site) regarding people's physical health needs.

We visited the following wards at Queen Mary's Hospital as part of this inspection;

Lavender Ward

Core service provided: Acute admission ward

Male/female/mixed: mixed

Capacity: 23 beds

Rose Ward

Core service provided: Acute admission ward

Male/female/mixed: female

Capacity: 23 beds

Laurels Ward

Core service provided: Acute admission ward

Male/female/mixed: male

Capacity: 23 beds

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The wards were safe, clean and suitable for older adults. People had access to fresh air.

Staff were trained in safeguarding and were aware of whistleblowing procedures. They knew how to report incidents and were able to give us examples, including safeguarding incidents.

Risk assessments were reviewed regularly and involved people using services and members of the multidisciplinary team. However, we found some incidents involving people who used the service that were not reflected in their care plans and risk management plans.

Staff told us they were able to discuss and learn from incidents in debriefs and monthly staff meetings.

Are services effective?

The wards were using guidelines from the National Institute for Health and Care Excellence to plan and deliver care. We saw that wards used standardised, evidence-based assessment tools to gather data about people and monitor their progress.

We saw that there was a clear care pathway for admitting, treating and discharging people. Staff told us how services worked together to manage the care pathway and progress notes reflected this.

The electronic patient notes system did not create records that truly reflected the care provided and it was difficult to see multidisciplinary team working.

We found examples of good practice and innovation on each ward. However, these ways of working were often isolated to one ward and did not appear to be shared between the services.

The wards carried out regular audits and made recommendations from them. Issues identified by audits were fed into the trust's Listening Into Action process.

Staff received the right level of mandatory training. However, specialist training relating to their area of work was lacking for some members of staff.

The wards did not have systems to track whether staff were participating in non-mandatory training, or to assess its effectiveness.

Staff told us there were sometimes financial barriers to getting the training they wanted and that it was currently difficult to access non-mandatory training.

Are services caring?

People told us they felt safe and involved in the ward and that staff listened to them. Staff interacted with people who used the service in a caring and respectful manner, answering questions and providing support when asked.

People who had been admitted several times said they were always allocated the same primary nurse so they did not have to build up new relationships each time.

Information for people using the service was displayed about patients' rights, activity timetables and information about the staff on duty.

Summary of findings

We saw examples of staff using their skills and knowledge of the people who used the service to involve them in the running of the ward. There was a weekly community meeting where the people who used the service were asked for their views.

Are services responsive to people's needs?

Each of the wards had an ethnicity lead, who ensured that people's needs, such as their religious or dietary needs, were met. However, we learned about a newly admitted person on one of the wards who did not speak English, but there were no plans to address their communication difficulties.

The home treatment team was based on the ward. People met the team when they were admitted, which lead to joint working both during people's stay and when they were discharged.

We saw that discharge plans and crisis contingency plans were in place for each person using the wards. People told us they received enough support to help them cope when their family members moved on from services.

Complaints were investigated and changes made to practice where necessary. Each ward also had an electronic feedback system.

Are services well-led?

Staff were aware of the trust's vision and values and told us how they interpreted these in their own practice.

Most staff said they felt that there was an open culture and that senior staff listened and valued their opinions. Staff felt valued by the organisation in general.

Staff told us they felt able to express their views and that they were part of a team that worked together well.

Staff said shifts were well-led, with clear plans drawn up by the nurse in charge. Ward managers felt they had good access to senior managers and that they were well supported.

Staff told us the appraisal system was very supportive and there were opportunities for professional development.

The trust's Listening into Action project was received positively and had helped bring about changes. Staff felt involved and were pleased to see changes happening.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We did not monitor responsibilities under the Mental Health Act 1983 at this location; however we examined the provider's responsibilities under the Mental Health Act at other locations and we have reported this within the overall provider report.

Acute admission wards

Overall, we found that the ward environments were safe, the wards were clean and staff were aware of risks. There were mechanisms to report and learn from incidents, but improvements were required in relation to risk assessment and management for individuals.

Staff were caring and compassionate in their interactions with people who used the service. People and their relatives were involved in planning their care, although records did not always reflect this. People were engaged in activities they felt were meaningful and therapeutic. The wards listened to people's feedback and involved them in making positive changes.

Staff often did not have direct access to specialist training. However, the wards responded to people's needs by engaging other services and working in collaboration with specialist teams.

Summary of findings

What people who use the location say

We left comment cards at Queen Mary's hospital but none of these were completed during our time on site. The comments from people using the service have been included throughout the report.

Areas for improvement

Action the provider MUST take to improve

- Ensure that where required comprehensive risk management plans are in place for people using the service where a risk to themselves or others had been identified.

Action the provider SHOULD take to improve

- Develop the electronic patient notes system to ensure that it supports and evidences true patient involvement in the planning of their care.
- Continue to monitor the mixed gender wards to ensure they comply fully with the national guidance.

Good practice

Our inspection team highlighted the following areas of good practice:

- We saw people using the service and staff interacting well together.
- We saw good involvement of each person in the planning and review of their care, and collaborative multidisciplinary team working.

Queen Mary's Hospital

Detailed Findings

Services we looked at:
Mental Health Act responsibilities and Acute admission wards.

Our inspection team

Our inspection team was led by:

Chair: Steven Michael Chief Executive South West Yorkshire Partnership NHS Foundation Trust.

Team Leader: Nicholas Smith Care Quality Commission.

The team included CQC inspectors and a variety of specialists including consultant psychiatrists, junior doctors, nurses, social workers, Mental Health Act Commissioners, psychologists, patient 'Experts by Experience' and senior managers.

Background to Queen Mary's Hospital

South West London and St George's Mental Health NHS Trust was formed in 1994 and operates from nine locations including Queen Mary's Hospital.

We visited the following wards at Queen Mary's Hospital as part of this inspection:

- Lavender Ward - acute admission ward for males and females aged 18 to 65 from the Richmond Crisis and Home Treatment Team.
- Rose Ward - acute admission ward providing in patient services for women from Wandsworth.
- Laurels Ward - acute admission ward with 23 beds for male patients who are between the ages of 18 and 75.

Why we carried out this inspection

We inspected this provider in the first wave of our new in-depth mental health inspection programme. We chose this provider because they are looking to achieve Foundation Trust status.

We selected this trust to review as they represented the variation in mental health care according to our new intelligent monitoring model. This looks at a wide range of data, including user and staff surveys, provider performance information and the views of the public and local partner organisations.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

We held a public listening event on the 10 February 2014 and also met with community groups on 7 and 12 March 2014. During our time on site we also met with individuals who asked to speak to the inspection team.

We carried out an announced visit between 17 and 21 March 2014. We undertook site visits at all the hospital

Detailed Findings

locations. We inspected all the acute inpatient services and crisis teams for adults of working age and older people. We visited all of the long stay/forensic/secure wards, child and adolescent mental health service (CAMHS) and all of the learning disability community teams. We also visited the specialist inpatient services and a sample of the community teams.

During the visit we held focus groups with a range of staff in the location, including nurses, doctors, therapists and allied health professionals. We talked with people who use services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences on the services received from the provider.

To get to the heart of people who use services' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team always inspects the following core services at each inspection:

- Mental Health Act responsibilities
- Acute admission wards
- Psychiatric intensive care units and health-based places of safety
- Long stay/forensic/secure services
- Child and adolescent mental health services
- Services for older people
- Services for people with learning disabilities or autism
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services
- Deaf mental health services

Mental Health Act responsibilities

Information about the service

The wards at Queen Mary's Hospital use the Mental Health Act to detain and treat people using the services when this is considered necessary.

Several people were detained on sections of the Mental Health Act 1983. We did not monitor responsibilities under the Mental Health Act 1983 at this location, however we examined the provider responsibilities under the Mental Health Act at other locations and we have reported this within the overall provider report.

Summary of findings

We did not monitor responsibilities under the Mental Health Act 1983 at this location; however we examined the provider responsibilities under the Mental Health Act at other locations and we have reported this within the overall provider report.

Acute admission wards

Information about the service

There are three acute admission wards operated by South West London and St George's Mental Health Trust at Queen Mary's Hospital. Lavender Ward provides assessment and psychological and pharmacological treatment for men and women aged 18-65. Rose Ward provides assessment and treatment for women only. Laurel Ward is a 23 bed assessment and treatment service for men aged 18-75.

Summary of findings

Overall, we found that the ward environments were safe, the wards were clean and staff were aware of risks. There were mechanisms to report and learn from incidents, but improvements were required in relation to risk assessment and management for individuals.

Staff were caring and compassionate in their interactions with people who used the service. People and their relatives were involved in planning their care, although records did not always reflect this. People were engaged in activities they felt were meaningful and therapeutic. The wards listened to people's feedback and involved them in making positive changes.

Staff often did not have direct access to specialist training. However, the wards responded to people's needs by engaging other services and working in collaboration with specialist teams.

Acute admission wards

Are acute admission wards safe?

Learning from incidents

At the time of our visit, the trust had a ban on plastic bags on the wards following incidents where people using the service had used them to attempt self-harm or suicide. We saw that paper bin bags and carrier bags were in use. However, staff were not able to tell us how the trust was working towards managing positive risk taking as part of the learning process. We found there were still some plastic bags on the wards, such as multipack crisp bags, but it was not clear how learning from incidents was being used to manage the risks.

Staff knew how to report incidents and were able to give examples, including safeguarding incidents. Staff told us they had opportunities to discuss and learn from incidents in debriefs and monthly staff meetings. We found incidents involving people who used the service that were not reflected in their care plans and risk management plans. Some risk incidents were flagged in people's records but this was not done consistently and we did not find evidence that incidents generated reviews of risk management plans or assessments.

Keeping people safe

People said they felt safe on the wards. Some ward areas did not allow clear lines of sight into adjoining areas and corridors, although most blind spots were managed using corner mirrors and one ward manager had proactively managed risks by swapping the communal lounge and dining room areas, so the more open and visible area became the lounge. People who used the service were aware that they should not enter areas designated to the opposite sex.

The service enabled some positive risk taking, for example managing self-harm by ensuring the person had access to regular medical checks and infection control measures rather than imposing restrictions.

Staff had undertaken training in safeguarding adults as part of their mandatory training and showed awareness of types of abuse. The service had responded appropriately to safeguarding concerns by raising alerts.

We did not see hand sanitising facilities in most ward areas, although there were sinks available for hand washing. A monthly hand washing audit had identified no concerns.

Ward areas appeared clean and people who used the service said they had no concerns in this area with one person telling us cleanliness has always been an area of excellence.

Risk management

The wards used a zoning system to give an 'at a glance' view of people's overall risk levels and this was reviewed daily. Staff understood the system and how it applied to mental capacity, observation levels and leave. There was, however, a lack of clarity around how specific risks were managed and about how assessments, incidents and responsive and proactive actions were linked. Some risk assessments had not been updated for several years, although some people's risk assessments were regularly updated. One person had no falls risk summary despite having a number of falls on the ward. Another person had recently been granted leave, as their overall risk was seen to reduce, but their risk summary was not updated. Staff were aware of how the zoning system was used to monitor overall risk levels for people who used the service, but it was difficult to track risk management in permanent records. This meant it was not possible to see how the wards were managing the risk of incidents being repeated for those people.

Safe staffing levels

The trust had recently increased staffing levels on the wards and there were plans to further increase staffing and reduce bed numbers. Staff felt there were enough staff for wards to remain safe and that there were enough longstanding staff members, supplemented by regular bank staff, who knew the wards well. When we visited Laurel Ward, we observed a number of people who used the service shouting and wandering around appearing unoccupied and increasingly agitated but we did not see staff present. This meant that nobody was available to deescalate the situation.

One of the wards had severely depleted staff numbers due to vacancies, sickness and maternity leave. This meant that high numbers of agency staff were being used to fill shifts. The ward was managing this by ensuring at least one permanent qualified nurse was on each shift and by using the same bank staff consistently. Managers looked at staffing levels daily and were able to call in extra cover if zoning levels indicated a need for more staff.

Acute admission wards

Are acute admission wards effective? (for example, treatment is effective)

Use of clinical guidelines and standards

Staff were able to tell us about national guidance, such as NICE guidelines, that the wards used to plan and deliver care. We were told about therapies such as family group work and psychosocial interventions in use on the wards. We saw that wards used standardised, evidence-based assessment tools to gather data about people and monitor their progress. Assessments were clear and of good quality.

Collaborative and multidisciplinary working

We saw from people's records that there was a clear care pathway for admission, treatment and discharge. Staff told us how services worked together to manage the care pathway and progress notes reflected this. However, we found that the RiO electronic data system did not facilitate record-keeping that was a true reflection of the care provided and sometimes it was difficult to see how different members of the multidisciplinary team had worked together to produce care plans. This meant that other services may struggle to obtain an accurate and complete picture of what a person's care looked like on the ward.

Staff teams discussed joint working with other services at handover and people's notes showed specialist involvement where required. Staff told us they attended regular reflective practice groups with the multidisciplinary team and had input from local universities about good practice in care planning. There were away days with shared learning and outside speakers. We were told there was a complex needs team, which was involved when people who used services had needs outside the scope of ward teams' expertise.

Whilst we found examples of good practice and innovation on each ward, we also found that these ways of working were often isolated to one ward and did not appear to be shared between the services.

Monitoring the quality of care

The wards carried out several regular audits and made recommendations from them. There were checks of discharge summaries and Care Programme Approach (CPA) review letters, which were 100% met. We saw results of monthly care plan audits, which identified some issues that were fed into the trust's Listening Into Action process. There was an audit on people's experience carried out using NICE guidance as a benchmark. We saw that some changes had been made in response to this feedback and it was discussed with staff at supervision. Wards had 'Learning and Improving' display boards to show the results of quality monitoring exercises.

Staff qualifications, competence and experience

Levels of mandatory training for staff were, in general, met. However, specialist training relating to their area of work was lacking for some staff members. Staff who told us about working with clinical guidelines were not always able to describe the content of that guidance or how it worked in practice. However, other staff were able to tell us how they used evidence based therapies and techniques. Staff would like copies of up-to-date clinical journals to be available.

The wards did not have systems to track staff participation in non-mandatory training or assess its effectiveness. However, there were opportunities for those who had undergone specialist training to take the lead on specific areas such as substance misuse and pass their knowledge to the staff team. Staff told us there were sometimes financial barriers to them getting the training they wanted and that it was currently difficult to access training other than mandatory training.

Are acute admission wards caring?

Choices, decisions and participation

Information was displayed about the services offered and about people's rights. However, people's records did not show that the understanding of their rights was regularly checked. There were posters showing activity timetables and information about the staff on duty.

We saw examples of how Lavender Ward made use of the skills and knowledge of people who used the service to involve them in the running of the ward, such as nominating a patient representative and giving one person who was a chef responsibility for improving the mealtime experience. This meant that people who used services were able to take on roles and carry out tasks that were meaningful to them during their stay on the ward. People were asked in weekly community meetings, and by the patient environment manager, for their views about

changes that were implemented and given the opportunity to make suggestions about how they would like the wards to operate. People said there were always choices about food.

Although progress notes and care planning meetings demonstrated how people were consulted about their views and proposed care was explained, care plans did not always reflect this. The 'client's view' section in the care plan was sometimes not filled in or did not correspond with the care that was being provided. This meant that people's views, goals and wishes might not be communicated effectively to other services involved in their future care although there were examples of good care plans with recovery goals. However, we did find that attempts had been made to include people's views in the restrictive templates and we found examples of how people's families were involved.

Effective communication with staff

We observed staff interacting with people who used the service in a caring and respectful manner, answering questions and providing support when asked. We also noted that people were discussed at handover using labels, e.g. 'alcohol abuser,' which could be seen as depersonalising and not respecting the individual person.

People who used the service appeared to be comfortable approaching staff when they required support. People who had been admitted several times said they were always allocated the same primary nurse so they did not have to build up new relationships each time.

Reviews of people's care were undertaken regularly and people were given copies of their care plans. Staff fed back at handover whether people were happy with their care plans although this was not documented. We attended a care planning meeting where a treatment plan was agreed with the person who used the service and they were able to feed back their views.

Support for people's needs

Electronic records showed that people's needs were being assessed, although some core assessments were incomplete. Care plans were disjointed and gave an unclear picture of people who used the service and how their needs were supported. For example, it was difficult to see how goals in care plans related to previously identified needs and how care described in progress notes, which were detailed and of good quality, related to care plans. However, staff were knowledgeable about the needs of the people who used the service and were able to give examples of how support reflected planned care.

People had access to physical health assessments and physical examinations on a regular basis. Where these indicated the need for specialist input or treatment, this was planned and provided.

Although staff felt there were enough staff to keep people safe, people who used the service and staff also felt that staffing levels were too low to spend sufficient time together. They said they often missed one-to-one meetings as a result. However, we saw activities were happening on the wards. People said activities were high quality, meaningful and therapeutic, including particularly creative activities such as writing and gardening.

Privacy and dignity

Staff showed an awareness of privacy and dignity issues, such as ensuring staff of the same sex as the person were available for support with intimate care. Staff told us they enforced strict rules about the use of camera phones. There were a variety of rooms for people to have private conversations in without being overheard, although payphones were situated in communal areas and were not private. Staff told us people could request to use the office phone if they wanted to talk in private.

People who used the service showed us lockable storage facilities and safes in their bedrooms.

Are acute admission wards responsive to people's needs?

(for example, to feedback?)

Meeting the needs of local communities

Wards had nominated leads for ethnicity, who ensured needs such as religious dietary needs were met. We learned about a newly admitted person on one of the wards who did not speak English, but there were no plans to address the communication difficulties.

At the time of our visit there were religious leaders employed by the trust to work regularly with people on the wards. However, it was fed back that these posts were due to be cut and there were concerns about this. Faith books and other items were available for people to use.

Acute admission wards

Staff and relatives of people who used the service expressed concern about the lack of female PICU services in the area. Due to the small number of referrals for female PICU beds, the trust contracts with another trust to provide this service.. This meant they had to care for people with a more acute presentation than before. It was clear from these conversations that acute beds are currently overstretched and one ward had admitted eleven people in the past week.

Working together in periods of change

We were told the home treatment team was based on the ward and were introduced to people who used the service. We saw examples of joint working in people's notes between the home treatment team and the ward. This meant people who used the service were familiar with the team who would be working with them after their discharge.

Staff told us about the support people receive when they moved on from inpatient services, including care planning and CPA reviews. We saw that discharge plans and crisis contingency plans were in place.

Relatives of people who used the service said they received enough support to help them cope when their family members moved on from services

Learning from concerns and complaints

Wards had electronic devices in communal areas for people who used the service and their relatives to enter feedback. People said they would like clearer instructions on using these. We saw 'You Said, We Did' boards that showed how the wards had responded to people's concerns, complaints and requests. Minutes from community meetings on Lavender Ward demonstrated that people were able to voice concerns and requests. Actions arising from these were noted in addition to changes that had already been made in response to previous concerns. However, it was not always clear whether actions had been followed up. People's concerns were discussed at handover on Laurel Ward but no resolutions were suggested. For example, one person had reported feeling agitated because of noise levels and staff responded by commenting that the person knew he was on a psychiatric ward but did not make suggestions about how to support the person.

Are acute admission wards well-led?

Governance, vision and culture

Staff were aware of the trust's vision and values and told us how they interpreted these in their own practice. Ward managers had clear plans to develop their wards and staff teams.

Most staff said they felt that there was an open culture and that senior staff listened and valued their opinions. Staff felt valued by the organisation in general.

Responding to staff concerns

Staff told us they felt able to express their views and that they were part of a team that worked well together. We saw supervision notes that showed staff were invited to express their views and discuss concerns with their managers.

We saw posters advertising a support service for staff.

Effective leadership

One of the wards we visited had recently undergone a change of management. It was evident that the new manager had made a lot of positive changes in a short space of time. Both staff and people who used the service told us they welcomed the changes.

Staff said shifts were well-led, with clear plans drawn up by the nurse in charge. Ward managers felt they had good access to senior managers and that they were well supported. Staff told us the appraisal system was very supportive and there were opportunities for professional development.

Staff engagement

Staff told us the trust's communication with them was very good. The trust's Chief Executive had recently visited the wards and staff said this was a positive experience. Some staff told us they were involved in trust-wide projects such as recruitment after having expressed concerns.

We were told that the trust's Listening into Action project was received positively and had helped bring about changes. Staff felt involved and were pleased to see changes happening.

However, staff told us specific issues around changes in shift patterns were not listened to and they felt this was having an impact on people who used the service.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983Diagnostic and screening proceduresTreatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows:Comprehensive risk management plans were not consistently being put in place for people using the service where a risk to themselves or others had been identified.This was a breach of Regulation 9(1)(b), 9(2)