

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

## Other specialist services

### Quality Report

Springfield University Hospital  
Tel:020 3513 6967  
Website:<http://www.swlstg-tr.nhs.uk>

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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)
RQY01	Springfield University Hospital	Bluebell ward	SW17 7DJ

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

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

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

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# Summary of findings

## Overall summary

- The majority of patients on Bluebell ward came from London and the south of England. The ward had a mix of hearing and deaf staff. All staff were proficient in British Sign Language (BSL). The staff were skilled and there was a high completion rate of mandatory training.
- There were systems in place to ensure that learning from incidents took place throughout the service. The ward had robust systems for dealing with complaints. Patients had complained about the admission of hearing patients onto Bluebell ward due to bed pressures in other parts of the trust. The trust had revised their protocol for admitting hearing patients onto the ward. They had put in additional safeguards.
- The ward had robust processes to manage medicines.
- Bluebell ward had nursing vacancies and there was regular use of bank and agency staff. The ward tried to use bank and agency staff who could sign. This meant that bank and agency staff could communicate with the deaf patients and staff.
- The comments from the patients using the service were generally positive. The patients were partners in their care and their voices were evident in their care plans. They participated in meetings and received information about their care.
- The staff were responsive to the needs of patients and supported patients to access spiritual support. The ward was able to provide patients with cultural and religion specific foods.

# Summary of findings

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

### **Are services safe?**

The layout of the ward did not allow staff to observe all areas. Therefore, the ward had fitted convex mirrors to assist with observing some areas of the ward. Female patients had to walk through the male patient area to get to other parts of the ward. There were staff on duty in the cross over area at all times to ensure the safety of patients.

The ward was clean and comfortably furnished. The ward had participated in the patient led assessment of care environment (PLACE). It had scored highly with a score of 98% for cleanliness and 88% for condition and appearance.

The staff were skilled. There were high completion rates of mandatory training.

There were staff vacancies. The ward used bank and agency staff to cover staff shortages.

There were doctors available to attend the ward day and night in an emergency.

The ward did not have a seclusion room instead it had two time-out (de-escalation) rooms. The ward had a policy and detailed procedures regarding the use of the time-out room.

The trust had adapted the alarm systems to meet the needs of the deaf patients and staff. The ward had vibrating alarms and flashing lights, which alerted individuals to an emergency.

The staff had a good understanding of safeguarding procedures. The staff ensured that patients were protected from harm. Staff were highly visible in all areas of the ward.

In the majority of cases, there were planned admissions onto the ward, which meant that staff had an understanding of patients' needs prior to their admission.

Staff had a good understanding of incident reporting, there was evidence of change and improvement because of learning from incidents.

However, on the day of inspection, the linen room was unlocked. These areas contained items that could have posed a risk to patients. This was brought to the attention of the ward staff who said that they would lock it immediately.

There was damaged flooring in the male time-out room. Staff had not updated a patient's risk assessments following an incident.

# Summary of findings

Hearing patients had been admitted onto the ward on 24 occasions between March 2015 and March 2016, due to bed pressures on the acute ward. Hearing staff from Bluebell had to care for these patients, which put pressure on the staff, as there were fewer staff to support the deaf patients.

## **Are services effective?**

Not inspected

## **Are services caring?**

Not inspected

## **Are services responsive to people's needs?**

The ward had a weekly bed-planning meeting and planned admissions onto the ward took place. The ward and community staff jointly assessed patients before admission onto the ward.

Patients had access to a garden. Patients who had impaired mobility had access to a lift.

All the patients on the ward were deaf or deaf blind. The ward had a mixture of hearing and deaf staff. The staff ensured that patient's families were involved in care if appropriate. The staff were able to access interpreters for families who did not speak English. This meant that families were able to contribute to review meetings for patients.

Patients had a range of activities available to them throughout the week and at weekends.

Staff responded appropriately to patient complaints and apologised when necessary.

There was a patient noticeboard on the ward, which displayed inspirational quotes. The staff had displayed pictures and biographical information of famous people who were deaf or hard of hearing.

However, there was limited information on the ward for patients who wanted to explore other aspects of their identity other than being deaf.

## **Are services well-led?**

Not inspected

# Summary of findings

## Information about the service

South West London and St George's Mental Health NHS Trust provides mental health services in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. It also provides national services including the national deaf services, which support deaf people with mental health needs.

Bluebell ward is an acute inpatient ward for deaf or deaf blind adults with mental health problems. NHS England commission beds on the ward, which means that the ward admits patients from across the country

The last inspection of the service was in March 2014. At the time the service was meeting essential standards, now known as fundamental standards.

## Our inspection team

The team that inspected the national deaf service on Bluebell ward comprised of:

- Two inspectors
- One specialist advisor, with experience of working in an acute ward for working age adults.

- One expert by experience. An expert by experience is someone who has used or cared for someone who has used mental health services.
- One British sign language interpreter.

## Why we carried out this inspection

This was an unannounced focused inspection. Staff and patients had raised concerns regarding the admission of acutely unwell hearing patients onto the ward and the impact it had on safe care and treatment for all patients.

## How we carried out this inspection

To fully understand the experience of people who use services, we asked the following questions of the service and provider:

- Is it safe?
- Is it responsive to people's needs?

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

During the inspection visit, the inspection team:

- visited Bluebell ward
- spoke with five patients who were using the service
- spoke with the manager of the ward
- attended a focus group
- spoke with five staff members; including doctors, nurses and a social worker
- attended and observed a ward hand-over meeting.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should ensure that patient risk assessments and management plans are reviewed and updated following risk incidents.

- The provider should ensure that non-patient areas are kept locked at all times. The provider should ensure that the fixtures and fittings in the time out room are well maintained.

# Summary of findings

- The provider should ensure that information for patients covers a wide range of topics, including areas of diversity.

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

# Other specialist services

## Detailed findings

**Name of service (e.g. ward/unit/team)**

**Name of CQC registered location**

Bluebell ward

Bluebell ward



# 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

- The ward was clean and comfortably furnished. Patients and assessors had reviewed the ward environment and undertaken a “patient led assessment of the care environment” survey of cleanliness. The ward had scored highly with a score of 98% for cleanliness and 88% for condition and appearance.
- The layout of the ward did not allow staff to observe all areas. To address this convex mirrors had been fitted to assist with observing some areas of the ward.
- The ward did not have a seclusion room. When patients displayed challenging behaviour, staff supported them in the time-out room. These rooms were a new feature on the ward and had previously been patient bedrooms. The ward had two time-out rooms, one for male and one for female patients. Both rooms were minimally furnished and provided a low stimulus environment for patients. The rooms were not comfortable and there was damaged flooring in the male time-out room. Neither room had ensuite bathroom facilities. The female time-out room was adjacent to a toilet. However, the toilet for the male time-out room was located along the male corridor, which meant male patients using the room had to pass other male patients bedrooms when they wanted to use the toilet. The ward had a policy dated March 2016, which provided guidance to staff regarding the use of the time-out room. The policy recommended that patients remain in the time-out rooms for the shortest time possible, the time-out room was not a seclusion room, and patients should never be locked in. Patients entered the room voluntarily and were aware that they could leave at any time. Staff supported patients in the time-out room at all times and nurses and clinicians reviewed patients on a regular basis.
- A designated nurse was infection control lead for the ward. There was information on display regarding good hand washing techniques and how staff should respond to a spillage of body fluids. The ward had an infection control audit and action plan dated September 2015.

The action plan had a number of recommendations that included assessing the immunisation requirements of the staff and tidying and removing inappropriate items from the clinic room to minimise the risk of contamination. The staff had reviewed and completed the recommendations on the action plan.

- The staff managed environmental risks on the ward effectively. A ligature risk assessment of the ward was undertaken annually and there were monthly checks. The ward had some ligature anchor points. To manage the risks from these staff increased the observation levels for high-risk patients. The trust had ensured that patients’ bedrooms had ligature free furniture. Some areas on the ward had recently been refurbished and the provider had fitted ligature proof door handles and taps.
- The ward was fitted with an alarm system, which meant that staff could summon assistance in an emergency. Staff tested the alarm system weekly. Deaf staff carried vibrating pagers to alert them to emergencies. The ward was also fitted with fire alarms. When the fire alarm was activated, the lights flashed and the patients’ headboards vibrated. This alerted deaf patients and staff to emergencies on the ward. Staff normally kept non-patient areas locked. However, on the day of the inspection, we found the door to the linen room was unlocked. Although staff were highly visible on the ward, the unlocked linen room was a risk to patients as it contained items, which could have posed a risk. This issue was brought to the attention of staff who stated that they would lock the room immediately.

### Safe staffing

- There were doctors available to attend the ward during the day and night in an emergency. The trust had set safe staffing levels on the ward for all shifts and these were usually met. The ward had at least two nurses and two health care assistants (HCA) on shift during the day. At night, there were at least two nurses and a HCA on shift. At the time of the inspection, there was one vacancy for a band 5 nurse and another band 5 nurse

# Are services safe?

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

was due to leave. The ward had recently recruited a new activity co-ordinator who was due to start in the next few weeks. There had been a 13.1% turnover of staff over the last 12 months and a sickness rate of 2.4%.

- The ward used bank and agency staff to cover shifts when there were staff shortages. There had been 22 shifts that had been unfilled by either agency or bank staff between 1 December 2015 and 29 February 2016. The ward manager tried whenever possible to use the same regular bank staff to cover staff shortages, this helped ensure continuity of care. The ward manager also used staff who were proficient in BSL, which meant that they were able to communicate with the patients and deaf staff.
- Hearing patients had been admitted onto the ward on 24 occasions between March 2015 and March 2016. This had put pressure on the ward staff that had to care for and treat additional patients who were acutely unwell. On two occasions, hearing patients remained on the ward for a period of four days. However, the majority of admissions lasted for one day. The ward manager tried to increase staffing levels on the ward to accommodate these unplanned admissions but this was not always possible.
- The ward provided new staff with an induction. This orientated new staff to the ward layout, safety issues and routines.
- Each patient had an allocated nurse; the patient noticeboard displayed the picture and name of the nurses.
- The ward ensured that staff shortages did not affect patients' escorted leave. When necessary the ward manager counted themselves in the staffing numbers to ensure that the patients got their leave.
- The staff on the ward were highly visible. There was always a member of staff on duty in the cross over area between the male and female ward.
- Staff had a programme of statutory and mandatory training. Sixteen staff out of 23 had completed all their mandatory training. The remaining staff had dates booked to complete their outstanding mandatory training. The overall completion rate for mandatory training was 98%.
- Patients were risk assessed on admission. Staff used a standardised risk assessment tool that was stored electronically and accessible to all staff. We reviewed the care records of four patients. We found completed risk assessments and risk management plans for all four patients. However, in one case the risk management plan had not been updated after an incident. The lack of update could mean that staff would not be aware of how best to mitigate the risk posed to patients.
- Records of the use of restraint and supportive holds were available. Between January 2015 and February 2016, there had been 23 incidents of restraint, none of them had been in the face down position. The trust provided training in conflict resolution (de-escalation) and proactive preventive interventions (restraint) and the majority of staff had been trained. The staff had adapted these techniques to meet the needs of the patient group. The staff ensured they could communicate with patients during de-escalation or restraint. A member of staff maintained eye contact with the patient. For deaf blind patients a member of staff had to use hands on signing which meant that the staff had to be within close proximity to the patient.
- The ward rarely used rapid tranquilisation with patients. Where rapid tranquilisation was used physical monitoring of patients took place at regular intervals. This was to ensure they were physically well.
- There was no seclusion room on the ward. The staff had used the seclusion unit on one occasion on another ward for a patient whose behaviour had become too difficult to manage on Bluebell ward. The ward had a protocol that when patients were taken to a seclusion room on another ward that they would be accompanied by a member of staff who could communicate with them in BSL.
- There were some blanket restrictions in place. The trust did not allow patients to bring certain items onto the ward because of risk, these included weapons, plastic bags and alcohol. There was a poster, which identified banned items displayed on the ward noticeboard. Staff searched and drug screened high-risk patients. Searching of patients was undertaken in a sensitive manner.
- The ward managed medicines safely. The medicines in the clinic room were stored correctly, they were labelled

## Assessing and managing risk to patients and staff

# Are services safe?

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

and in date. The staff had appropriate arrangements in place to store and manage controlled drugs. The ward had a special bin to dispose of medicines that were no longer required. The pharmacist technician visited the ward weekly to check the medications.

- Staff on the ward had a good understanding of safeguarding procedures and were able to protect people at risk of abuse. The ward had robust processes to ensure that patients using computers and the internet were protected and that they did not present a risk to others as a result of their computer usage.
- The ward had designated visiting times and vulnerable visitors, for example, children were restricted to the visitors room to ensure their safety.

## Track record on safety

- There had been 216 incidents on the ward between January 2015 and February 2016. Two incidents had been categorised as moderate with a short-term risk of harm. Thirty-eight incidents had been categorised as minimum harm with patients requiring extra observation. Nine incidents were incidents that could have led to harm but did not and 160 incidents had been categorised as “no harm occurred”.

## Reporting incidents and learning from when things go wrong

- Hearing patients had been admitted onto the ward on 24 occasions in the last 12 months. These admissions were due to a lack of beds on the adult acute wards. This had caused concern for both the patients and staff on Bluebell ward. Fourteen of the patients had been admitted onto the ward during a night shift when staffing levels were lower. In the majority of cases, these patients were subject to increased observation levels, which staff from Bluebell ward had to provide. Staff raised the issue of hearing patients being admitted onto the ward with the local authority adult safeguarding team. The staff had also raised an incident report through the trust’s incident reporting system. The staff met with patients to discuss the incident. Staff informed patients that they would continue to monitor all admissions of hearing patients onto the ward.
- There was additional evidence of learning because of incidents on the ward. The ward had improved its referral and screening process of new patients as a result of an incident of violence and aggression.
- The ward manager, modern matron and operational manager maintained an overview of all incidents reported on the ward.
- The ward manager shared feedback about incidents with staff in ward business meetings

# Are services effective?

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

### Not inspected

# Are services caring?

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

## Our findings

### Not inspected

# Are services responsive to people's needs?

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

## Our findings

### Access and discharge

- The ward operated as a national deaf inpatient mental health ward. The majority of patients came from London and the south of England. All the patients were deaf or deaf blind.
- Planned admissions onto the ward took place. The ward had a weekly bed-planning meeting. Staff from the ward and the community mental health teams attended this meeting. The staff discussed patients who were becoming unwell and made plans for admitting them into hospital. The ward and community staff jointly assessed patients before admission to the ward. If the ward could not admit a patient, staff liaised with similar units in other parts of the country to ensure patients received care and treatment as quickly as possible.
- The ward had limited access to psychiatric intensive care unit (PICU) beds for patients who became acutely unwell. However, whenever possible, the ward tried to avoid using these beds, as the PICU ward environment was not appropriate for patients who were deaf. To the specialist nature of the beds required. When patients became acutely unwell, depending on clinical risk assessment, the ward manager would increase the numbers of staff assigned to care for the patient. This meant that the patient could remain on Bluebell ward.
- The average bed occupancy on the ward for the past six months was 88%.
- Staff ensured that inpatient beds were kept available for patients whilst they were home on leave.
- Delays to patient discharge did not take place unless there were clinical reasons. The average length of stay on the ward was about three to four months. The longest length of stay on the ward was 12 months. There had been no delayed discharges. Due to the complex needs of the patients, a number required discharge to a supportive placement. To ensure that patients were discharged to a suitable placement, staff liaised with the patients' care co-ordinators.

### The facilities promote recovery, comfort, dignity and confidentiality

- Patients could personalise their bedrooms and were able to keep their belongings safe and secure. Bathroom and toilet facilities were separate for male and female patients.
- There was a range of rooms and equipment to support patient treatment and care including a clinic room, visitors' room, quiet lounge and occupational therapy room.
- Patients could have their mobile phones dependant on clinical risk. Patients could also use the ward-based computer to contact friends and family via email or Skype.
- Patients had access to a garden. There was a lift available for those who had impaired mobility.
- The PLACE assessment had scored the ward food at 85.4%.
- Patients had access to hot drinks and snacks outside of meal times.
- The ward had recently recruited a new activities co-ordinator and this member of staff was due to start week beginning the 14 March 2016. As a result of the vacancy, the number of activities on the ward had been restricted. Despite this, patients were able to attend movie nights, news and views group and a regular breakfast club.

### Meeting the needs of all people who use the service

- The ward was on the first floor. People with mobility difficulties could access the ward via a lift. The entry to the ward had a video intercom, which meant that deaf patients could communicate with the person answering the door using sign language.
- The occupational therapist was the disability champion for the ward and was able to raise awareness of the needs of the particular patient group within the trust.
- The ward was moving to a purpose built building for deaf people within the next four years. Ward staff had met with the architects to discuss the design of the new ward to ensure that was fit for purpose.

# Are services responsive to people's needs?

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

- There was easy access to a BSL interpreter for patients who needed support to communicate with staff. Staff were able to access interpreters for families who did not speak English. This meant that families were able to contribute to review meetings for patients.
- The ward was able to provide food to meet the dietary requirements of different religious and ethnic groups.
- The staff supported patients to access spiritual support. For example, a chaplain visited the ward regularly.
- The ward provided information on a range of services including advocacy, the trust's complaints process and leaflets on mental health. The ward had pictures of the ward staff and their job titles displayed on a noticeboard.
- There was a patient noticeboard on the ward, which displayed inspirational quotes. The staff had displayed pictures and biographical information of famous people who were deaf or hard of hearing. The ward recognised the diverse needs of patients. It celebrated black history month but did not celebrate lesbian, gay, bisexual, trans (LGBT) history month. There was limited information on the ward for patients who wanted to explore other aspects of their identity other than being deaf.
- The patients' pictorial care plans had a section for complaints and compliments. Staff explained the complaints process to patients in the MDT care plan review meeting.
- There had been 12 complaints in the last 12 months. The trust partially upheld one complaint. The trust had responded appropriately to the complaint. The provider apologised for any misunderstanding that had taken place. The parliamentary and health service ombudsman (PHSO) had not received any complaints regarding the ward.
- As well as using the formal trust complaints process, patients were also able provide feedback through the real time feedback machine on the ward. The ward was adapting the real time feedback machine on the ward so that it was more appropriate to patients who used BSL.
- Staff learned from complaints and concerns and made improvements on the ward. For example, patients complained to the trust in March 2015 regarding the admission of hearing patients onto the ward. The staff had met with the patients to discuss this. Staff raised the issue through the trust's clinical governance structure, NHS England and the local safeguarding team. In response, the trust had revised the protocol for admitting hearing patients onto the ward. The new admission protocol stated that only "settled" hearing patients would be admitted and that they would stay on the ward for the shortest period possible.

## Listening to and learning from concerns and complaints

# Are services well-led?

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

## Our findings

### Not inspected