LAVENDER WARD

ENTER & VIEW REPORT

Queen Mary's Hospital, Roehampton Lane, London, SW15 5PN

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Visit Dates: 14/07/2017, 19/07/2017 & 21/08/2017

Contents

Introduction

Following analysis of the Healthwatch Richmond database at the end of 2016 and a series of in-depth interviews with service users at the Richmond Wellbeing Centre in early 2017, it was evident that there was a high level of concern surrounding staffing levels on Lavender Ward and its impact on patient engagement as well as poor therapeutic provision of ward based activities. Therefore, Healthwatch Richmond made a decision to conduct Enter & View visits to Lavender Ward on 14th July, 19th July and 21st August 2017. Visits took place both in the morning and afternoon in order to capture a more complete picture of the daily practices and care provided to patients on an average day on the ward. Two staff members and four Healthwatch volunteers were recruited to the project, three of whom have current or previous professional backgrounds in mental health.

Aims of the Visit

This Enter & View visit was designed to achieve the following:

1. Collect the current views and experiences of staff, patients and their carers on Lavender Ward
2. Carry out an observational audit to address previous concerns raised over the safety and quality of care observed on Lavender Ward
3. Assess physical aspects of the ward environment
4. To gain a snapshot of the extent of awareness of the OBC at ward level in South West London and St George's Mental Health NHS Trust (SWLSTG)

Background Information

Lavender Ward is located at Queen Mary's Hospital, Roehampton and is run by South West London and St. George's NHS Trust. It is a 23-bedded mixed sex acute admissions unit for adults (18-65) experiencing a severe episode of mental illness and other related disorders. This includes patients presenting with depression, anxiety, bi-polar disorder, schizophrenia, psychosis, substance abuse and personality disorders. It accepts referrals for patients on Section 2, Section 3 or Section 37/41 of the Mental Health Act (MHA, 1983) as well as informal admissions. A summary of the detaining sections used in the MHA can be found in the table below.

Summary of detaining sections

Section 2 -	Refers to patients who can be kept in hospital for up to 28 days for assessment and treatment. A Section 2 cannot be renewed and patients can either stay in hospital informally, be discharged or transferred to a Section 3 for further treatment.
Section 3 -	Patients on this section can be kept in hospital for up to 6 months and is usually applied to people who are well known to mental health services or patients who have been transferred from a Section 2. A Section 3 can be renewed for a further 6 months and subsequently for 1 year in further renewals. Applications for Sections 2 and 3 must be made by an Approved Mental Health Professional (AMPH) or nearest relative and be approved by 2 doctors. Patients on Section 2 have a right to appeal their detention to a Tribunal during the first 14 days of their admission and can also appeal to Mental Health Act managers at any time. Patients on Section 3 have a right to appeal to a Tribunal once during the 6-month period. If the section is renewed, patients have a right to appeal once during the second 6 months and then once over the 12-month period in subsequent renewals. Section 3 patients can also appeal to Mental Health Act managers at any point during their detention.
Section 37 -	A magistrates court or the Crown Court can apply for this section for people who are in prison but need to be in hospital for treatment of a serious mental health problem.
Section 41 –	This is a hospital restriction order which may be added to a Section 37 by the Crown Court to safeguard the interests of the general public.

Admissions to Lavender Ward can originate from any Trust Home Treatment Team or local A&E departments.

Lavender Ward provides assessment and treatment through 24-hour care and observation by a highly specialised ward-based multi-disciplinary team (MDT) which is composed of:

- Nurses
- Doctors
- Occupational Therapist
- Activity Coordinators
- Healthcare Assistants

Patients should be assessed by a doctor within 24 hours of admission and allocated a bed space according to clinical need, but which may also depend on availability. As part of the admission process, patients should be notified of who their key nurse will be for their admission. The key nurse is responsible for working through the patient's care plan with them and identifying treatment goals or outcomes. Patient care plans are all individualised and adapted to the individual's own physical and mental health needs. Care plans are shared and developed by the

multi-disciplinary team (MDT) and where possible with close collaboration from the patient. General progress towards treatment goals is monitored daily by the patient's named nurse for that shift. Patient treatment and care is also reviewed formally by the MDT during weekly ward rounds. Lavender Ward can also receive input and support from social workers, community psychiatric nurses, physiotherapists and other professionals to assist with formal discharge planning and easing the patient's transition back into the community.

Ward Environment

While Lavender Ward is a mixed sex unit; female and male bedrooms and personal hygiene facilities are completely segregated. There is a recreational area with access to a TV and computer with internet access. The kitchen is open 24 hours a day for drinks and making snacks and patients are encouraged to use as part of their therapy and to improve their independence. There is a dedicated dining area where patients are required to eat their meals and there is provision for patients to eat outside on the patio should they prefer. There is also a separate quiet room which is reserved as a therapeutic space rather than for recreational use and needs to be accessed through a nurse for an agreed period of time. A separate female only lounge is available.

What We Did

To understand the existing service user data on standards on Lavender Ward, Healthwatch Richmond reviewed the complaints, concerns and comments it had received from late 2016 to early 2017. In addition, we also asked Lavender Ward to provide information on:

- Trends in admissions in the past 12 months
- Bank or agency staff use
- Staff vacancies
- Discharge policies
- Policies for assessing capacity
- Average length of stay in the past 12 months

This was to gain a better overall understanding of how Lavender Ward was currently managed and an insight into how it was performing in terms of staff retention and recruitment and the nature of length of stays. Lavender Ward provided a comprehensive response to the data requested.

At the time of response, Lavender Ward had 2 healthcare assistant (HCA) vacancies and in the month of April had put out 8 nurse shifts and 13 HCA shifts to bank or agency. This suggests that Lavender Ward is performing well in clinical recruitment and retention and sharply contrasts with the Trust-wide figure of 19.9% of clinical posts vacant, as detailed in the Trust's Quality and Performance Report in May, 2017. There was still a small reliance on temporary staffing which may reflect the need for extra staff to provide increased levels of observations for patients who are particularly unwell.

The average length of stay for patients had stayed fairly static over the last 12 months with an average length of stay of 36.5 days apart from the months of August and December which saw a spike where the average length of stay rose to 79 days. This is slightly higher than the Trust target of 33.9 days but is mostly in line with the Trust actual average length of stay of 35.6 days. In a comment over the trends in admissions over the last 12 months, the ward manager stated that a number of patients are well known to services. Some patients will relapse in the community due to non-compliance with their discharge medication requiring re-admission. Some patients will be delayed on discharge due to a lack of suitable housing or the patient's home is not in a state that would be conducive to recovery.

This data was used to inform the qualitative interview audits that would be used with patients (Appendix 1), staff (Appendix 2), carers (Appendix 3) and the ward observational audit (Appendix 4).

Method

There was a preliminary meeting between Healthwatch Richmond and Lavender Ward in March 2017 to discuss the project objectives and how this would be achieved through an Enter & View visit. It was also an opportunity to learn more about the underlying structure of the ward, including the patients, the ward timetable and staff numbers. Initial visit dates were then confirmed for 14th July 2017 and 19th July 2017. It was felt this was a very productive meeting on both sides where the ward was very receptive and open about us visiting and carrying out interviews.

Healthwatch Richmond selected a team of 4 volunteers and met to review the data provided by Lavender Ward, the interview questions and observational audit. It was agreed that the audits were robust and appropriate to assess areas of concern and observe general practice on the ward. It was agreed that the team would split into pairs of two during each visit to ensure as much coverage as possible when talking to staff, carers or patients.

Our primary objective was to provide a snapshot of the care and conditions observed during those visits and to capture an in-depth and encompassing view of the experiences of patients and staff currently on Lavender Ward. This was attained through:

- Conducting broad semi-structured interviews with staff and patients
- Observing areas of practice and physical aspects of the ward environment
- Amalgamating volunteer reports to pinpoint areas of concern, good practice and potential areas for further exploration

We visited Lavender Ward on the 14th & 19th July 2017 and 21st August 2017 and we were able to observe the atmosphere and conditions during lunch and ward rounds and the patient community meeting. Visits were up to 2 hours in duration.

After each visit the team met to debrief and discuss how the interviews had progressed and raise any other comments or concerns.

Limitations

The Enter & View visit was not designed nor does it claim to provide a representative view of the staff and patients on Lavender Ward, Queen Mary's Hospital. The patients we interviewed in this project were all being treated for an acute episode of mental illness and therefore not all had the motivation or the capacity to fully engage in being interviewed.

We spoke to a third of patients during our visit. Their responses will naturally be subject to the care they have personally experienced and may also be shaped by their diagnosis and severity of illness. Therefore responses may not be able to be generalised.

Qualitative analysis was solely used in this report which allowed us to identify key themes. However, qualitative analysis is not able to provide an accurate sense of scale to issues raised as the data cannot be robustly quantified.

Analysis

The qualitative data analysis was conducted using an approach based on the following:

- Individual volunteer reports from patient and staff interviews and observational audits were reviewed and categorised into themes
- Analysing the data according to the themes and splitting into sub-themes where appropriate
- Preparing a descriptive summary of the themes including assigning an overall tone to the comments (positive, neutral, negative, no data)

The following themes that have emerged have been grouped according to audit questions and some have been narrowed into sub-themes.

Communication

The patients we spoke to told us that in terms of staff attitudes and general approach, they would rate communication as being good. One patient said they felt listened to and that staff were responsive whenever they raised any comments or concerns. Patients also remembered staff presenting themselves very well during their admission which typically can be an anxiety-provoking time for patients and felt their communication style to be appropriate. One patient said that they had received a friendly welcome, including a full tour of the ward and information on the ward timetable and visiting times. Another patient commented that staff ensured they knew and understood the reasons for their admission.

However, there does appear to be a gap in communication regarding patients' knowledge of having a designated key nurse. We were informed by the ward manager that upon admission all patients are assigned a key or primary nurse who is responsible for the development and implementation of the patient's care plan.

This is a standard which should be complied with for every patient and patients should be told the name of their key nurse as part of the admission process. Some patients were quite emphatic however that they were not aware of this role on the ward. From a patient's perspective, this role appears to be being confused with the allocated named nurse which changes according to the shift rota and is the person who patients are directed to for any day to day issues. One patient said they did not know who their key nurse was and asked if it changed every day. Another patient who had been admitted within the last 2 days told us they had not been informed of a personalised care plan by staff yet.

The patient community meeting is a longstanding arrangement to monitor and track issues or suggestions which is coordinated by staff once a week. We were told by staff this system works well to actively follow up present issues for patients. However, the community meeting we attended seemed chaotic as:

1. There were no records present from the previous meeting
2. Some patients talked over others leaving them frustrated and culminated in some patients walking out with one saying "there's no point staying here"
3. A low number of patients at the meeting

One patient thought the ward would benefit from a dedicated comments box which would act as a more informal and anonymous way to leave comments and that the only alternative, which is through email, could be too limiting as the computer was not always free and some patients are not comfortable with using email. This patient was also uncertain on how to provide feedback once they had been discharged.

Care & Treatment Plans

We were given a detailed overview from staff of how care plans are formulated on the ward and were told there was a heavy focus on this being done in collaboration with the patient where the individual's presentation allowed it. The allocated primary nurse should conduct a full assessment of mental health needs through a one to one with the patient and share this with the multi-disciplinary team (MDT) to enable comprehensive implementation. For example, certain elements of the patient's care plan are incorporated through therapeutic group activities run by the activities coordinator. The discharge planning process is also often linked through the patient's care plan. Progress should then be monitored daily by the named nurse and fed back for the MDT to review weekly. Patients should be kept informed and all aspects of their care should be continuously discussed with them.

One patient who was due to be discharged that day, confirmed that their discharge plan was discussed with them in a ward round but denied any knowledge of having a personal care plan throughout their admission and said "this was not done in collaboration with me". We also spoke to a patient who had been admitted 3 days prior to our visit who said they did not have any awareness of having a care plan.

Accommodation

While staff thought they worked through care plans well as a team and reached universal satisfactory decisions, the ward manager and consultant told us they had encountered problems when the Council has needed to be involved in the advancement of a patient's care plan. For example, if one of the treatment recommendations is a temporary discharge placement in supported accommodation then staff may run into obstacles due to a limited number of funded placements. According to the Council's Mental Health Joint Commissioning Strategy for Adults 2010-2015, there are a total of 12 accommodation based supported housing schemes in Richmond delivered by voluntary sector organisations, which offer 70 bed spaces with 20,000 hours of visiting support contracted. It is not clear at this time whether supported housing will be increased to reduce the number of delayed discharges.

Staff told us that a major issue for them was discharging patients where input from social services is needed, especially where they also had housing needs was an increasing challenge.

The Council's Joint Mental Health Strategy Implementation Plan for 2014-2016, states that reconfiguration of community mental health teams (CMHTs) to form new models of care will reduce the need for aftercare in temporary high support accommodation, better meet the needs of service users in their own homes and help prevent some acute or emergency admissions to hospital. Better care in the community should also reduce situations where families do not feel able to cope with having the patient discharged home leaving supported accommodation as the only alternative.

Provision of Therapeutic Activities

Staff and patients were in strong agreement that a more stimulating variety of patient activities needed to be introduced to the therapy programme. Currently they are limited in content and some patients found it difficult to pass the time. One patient commented "there is not enough to challenge or interest" and was under the impression that funding for activities was limited. Newspapers are available at no cost to patients, however one patient felt there were not enough to be distributed properly as they rarely had access to one. Patients also complained that even basic recreational items such as CDs or DVDs were not available. Going forward, patients told us they would like to see the introduction of:

- Music
- Board & card games
- Paid work (like poppy making) and placements
- Day trips (patients said these do take place and are very popular so more would be welcomed)
- More physical exercise related groups

Patients generally felt more creativity is needed from the Occupational Therapy department to extend activities to meet all patients' interests, taking them in a

direction where activities are less sedentary in nature and involve taking patients outside the ward. One patient in particular felt this would be beneficial as going outside would help with their anxiety. Another patient commented that exercise would have been a good addition to their treatment regime. This seemed to be particularly felt by patients on section who had not been granted leave to go outside the ward and therefore felt that opportunities to exercise were limited. One patient told us they were keen to take part in walking groups and felt that walking and talking would be particularly therapeutic.

One staff member reported there has been a regular pattern of activities being cancelled if the occupational therapist or activities coordinator is not available. This was also echoed by a number of patients we spoke to. Therefore, it was encouraging to hear that other staff groups are going to be trained to run activities to avoid sessions being missed in future.

It appears that the team have heard patients' concerns as a number of changes were in motion during our visits. We were informed that an activities coordinator was now in post 7 days per week which was encouraging to hear and from a practical perspective should mean there are no issues in rolling out new additional activities. During our third visit, we found out a table tennis table had been delivered. Unfortunately, staff are not allowed to assemble this themselves but have to submit this as a work order to the maintenance department who are permanently based at another site. In light of previous experiences, staff and patients alike expressed concerns over the time this process would take.

In addition, the Trust has allocated extra funding to wards for recreational items which will provide a means of distraction for patients when the smoking ban goes into full effect. The ward has therefore submitted a list which includes a karaoke machine, drums and exercise related items such as a Wii games console and a basketball hoop which should also help in meeting patient demand for more physical activities on the ward when they are not able to go on leave. The occupational therapist has specified for the basketball hoop to be detachable so it is not a potential ligature point and patients can use it safely.

One patient expressed a sentiment which we find hard to disagree with where the requested recreational items should already be available as standard for patients regardless of new events such as the smoking ban. It is also important to note that the items on the list remain provisional and subject to financial approval from senior management. Therefore, we cannot currently say with confidence how much recreational provision will improve in the future.

Meals

Patients agreed that the overall quality of the food was of a good standard although some thought meals would benefit from extra portions of fruit or vegetables. One patient stated that Halal meals are available as and when required by patients. The Enter & View team agreed that the menu had enough variation at the lunch we observed. Staff explained that patients choose the menu a week in advance at the community meeting. Staff then over order on meals to increase flexibility and ensure there is a selection of alternatives if a set meal was

refused. Staff were very proactive in their attempts to ensure all provisions are made so that patients receive a meal of their choice. Meals are seen as a social event on the ward and staff will make every effort to encourage patients to eat as a group. There is a dedicated dining area separate from the main lounge to encourage patients to socialise. Patients also have the option of eating outside on the patio.

Outside of meal times patients can access beverages including tea or coffee. Patients felt that a milk machine would be a useful addition to Lavender which is something Lilac Ward at Queen Mary's and a ward in Tolworth already benefit from as it greatly eases access and avoids distracting staff from other patient care.

Ward Environment

Safety

Some significant security concerns were reported to us by patients on our visits concerning room locks. One patients said that the lock on their bedroom had been faulty for some time and said this had caused a breach in their personal space and safety as someone had entered their room without permission. Another patient said they had not been provided with a key to lock their room and had needed to ask nurses several times.

When considering the general atmosphere on the ward, this was variable throughout our three visits and was influenced in part by levels of acuity and staff presence in patient areas. There were periods during our visits where the Enter & View team were in full agreement that the ward felt contained and safe to walk around. One patient also commented to us they had always felt safe throughout their admission. A prominent feature noted was the capacity to have the windows open with the appropriate safety features in place. Volunteers felt that this facilitated and contributed to a fresh and comfortable atmosphere on the ward.

However, when several patients became disruptive this rapidly altered the environment to one which was unsettling and distressing for other patients. We observed several patients leaving the lounge area during a period of increased noise and disruption. One patient left the room after shouting *"This is doing my f***ing head in"*. Another patient grew visibly upset and left crying. On this occasion we observed very little staff activity in the vicinity at this time when several situations required de-escalation and culminated in some patients resorting to telling disruptive patients to be quiet.

A number of patients also highlighted to us the negative impact that disruptive or noisy patients had on the atmosphere of the ward. One patient described it as being a constant problem and that it had been their main concern throughout their admission. Another patient said that on Lavender Ward they had witnessed less fighting compared to other acute wards but there was still too much hassle from other patients. Another patient stated *"the other patients are stressful. I just want to go out. I just want to leave".* In terms of safe places for patients to retreat to for some privacy, there is a separate female only lounge. This is usually

kept locked to maintain the safety of patients at risk of suicidal thoughts as there is a ligature point from the cord of the TV. Patients can ask staff for access at any time. There is however no equivalent separate space for male patients. Staff pointed out the dedicated Quiet Room is there for all patients. This is primarily used for therapeutic activities rather than recreational use so this would not be an appropriate alternative space for all of the time.

We were told access to boiling water is actively managed as a security risk. If there is a patient at risk of harming themselves or others and is usually kept locked. One staff member commented that the safety and security of staff and patients is of paramount importance to the Trust however no security cameras are used on the ward in order to preserve the privacy and dignity of patients. One volunteer noted with concern during the visit that there were no staff present at blind corners to promote safety for patients and staff.

Maintenance

Our team observed that the ward was generally clean and well-kept in all areas with the exception of the patio and some outstanding maintenance work. In one of the bathrooms the skirting was damaged and coming away from the wall, in another the grip rail was missing. The sofas appeared quite worn and one had a large crack. One patient also told us that graffiti by a previous patient had not been removed from their bedroom walls. We were told that this is a private finance initiative hospital (PFI - which refers to a procurement method where public sector infrastructure is delivered by private sector investment) and that maintenance is therefore is carried out by the PFI body rather than South West London and St Georges' NHS Trust. Staff were not able to say whether this has caused any unnecessary time lags.

One particular area that was not rated as highly for environmental maintenance was the patio. On the day of our first visit most of the plants in the patio area had been recently damaged by a patient. The majority of the bins were also overflowing with rubbish. Therefore, it was highly encouraging to see a significant improvement less than a week later. The patients had re-painted the plant pots in bright colours and had gone to the garden centre to purchase some new plants. In addition, the ward manager informed us that funding had recently been approved for some fake grass to further improve the aesthetics of the outside area.

Access to Information

Activities and therapy notices were safely contained and displayed in a glass cabinet although the recovery course was noted to be out of date. Cleaning notices, PALS and advocacy information along with support for carers were also clearly displayed in an open area making it accessible for patients and visitors. There was also a dedicated staff board including pictures and the staff member's role. For patients with hearing or visual disabilities, there was no information currently on display. However, a member of staff informed us that a hearing loop is available for ward rounds and that they are able to obtain braille to provide ward information for those who are visually impaired. Staff also have the contact

details for interpreter services to aid in communicating with those who have language difficulties. It was also reassuring to hear that there was a designated disability champion for Lavender Ward, currently the Occupational Therapist.

Patients generally felt they could access the information and resources they needed to. However, one patient reported difficulties in accessing spontaneous, ad hoc information from bank staff, *"sometimes it was hard because there were no regular staff and they didn't know things".*

Medication

One patient we spoke to said staff had made him aware of what medication he had been prescribed and had been receiving them at the right intervals. Volunteers were told by staff that pharmacists from the Trust visit the ward to assess the medication for each new admission. Medication is again re-visited prior to discharge so pharmacists can ensure the "right mix" is being taken by the patient once they are in the community.

Discharge Planning Process

The input from doctors on discharge planning was rated positively by the patients we interviewed with one saying that their discharge was consistently discussed with them in ward round. Consequently, the patient had felt supported during the discharge process and had been provided with information on what support will be available to them in the community.

Staff told us that discharge planning has become an increasingly difficult process with delayed discharges presenting as one of the leading sources of frustration for staff and patients. Nursing and medical staff told volunteers this has partly stemmed from social services no longer being part of the Trust's community mental health team (CMHT). Social workers will now only attend a patient's ward round under the current arrangement and attendance for this has been described by staff as sporadic. A doctor told us that this reduction has been felt by staff and patients and has led to a deterioration in care for patients. Overall, this has resulted in staff feeling under more pressure as it is now more time consuming to deal with social care related issues to a patient's discharge. Staff told us that engagement from social services can vary according to borough, with Richmond being described as the most accessible. This was partly attributed to staff being familiar with the phone directory and knowing who to contact.

We spoke to one patient who had needed a lot of input from social services due to ongoing mobility issues. They told us they had shared one short meeting with their social worker. The social worker had also attended two ward rounds but it was unclear to the patient whether there would be further input from social services once he/she had been discharged. Social services had organised a Personal Assistant to be in place to enable discharge home. However, this patient still had concerns about mobilising outdoors or on the stairs as they had only been issued with a frame suitable for indoor use. This meant they had not been able to partake in physiotherapy or occupational therapy and therefore had not been assessed,

leaving them uncertain about their ability to travel to subsequent welfare or outpatient appointments.

Since the reconfiguration, most staff felt that the relationship with social services had deteriorated. Staff told us *"it is hard to get hold of them. Trust staff are now doing thing social workers used to do"* and *"it changed overnight"*. Most staff professed a lack of knowledge around follow-up care from social services with one staff member saying he/she felt confused about the location of services and management structure.

A lack of appropriate housing or funded placements in rehabilitation units can also present a significant barrier to discharge. For example, there was a patient on the ward at the time our visit who was medically fit for discharge but no appropriate supported accommodation could be sourced and we were told by staff that *"no one will take her".* Prior to this, there was a wheelchair-bound patient who had to stay on the ward for approximately a year. Due to a complex presentation involving both physical and mental health needs it was incredibly challenging for staff to identify a suitable home placement with the appropriate package of care. Staff told us there was a sense of reluctance from several providers who gave the impression they did not want to take on a patient with such complex needs which duly increased the pressure on staff.

Situations such as these have been compounded by changes to the discharge coordinator role. Currently the post holder works across Lavender and Lilacs wards which can mean they are unable to attend the weekly ward round thereby limiting their input. The discharge coordinator is formally known as the Acute Care Practitioner (ACP). The Trust is exploring the possibility of appointing a second clinical practitioner to Lavender and Lilacs wards to assist the ACP, until the Hospital Discharge Team has been set up by the Local Authorities. We were told by the Trust that the implementation of this team has unfortunately been delayed. Staff reported that Lavender Ward used to have a full time designated discharge coordinator which was a valuable role as they were able to source appropriate discharge placements and track and escalate any issues with social services or the Council. Staff told us that without the discharge coordinators support, making arrangements such as deep cleans of a patient's home can be lengthy to organise and cause unnecessary delay to discharge. Staff said that nurses have been able to take over this role themselves however this can subsequently impact the care they provide to patients as their attention can need to be elsewhere. To try and partly address this, the ward consultant has utilised the administrator to facilitate the discharge process and has asked them to take over the setup of discharge planning meetings and ensure this is in conjunction with the patient's care coordinator in the community.

Staffing

Staff Presence and Engagement

Throughout our visits, HWR volunteers observed several examples of compassionate and responsive care to patients who were in distress. One patient

was lying down in a very emotional state and a nurse was on the floor with them, holding their hand and maintaining a supportive presence beside them. Two other patients were also on the floor and talking, with a staff member also sitting on the floor at their level. Volunteers also noted that any time a patient approached staff they gained their immediate attention. One patient who had lost some mobility just prior to this admission and now required assistance with activities of daily living spoke highly of staff and the friendly, personalised care they had received, including attention to personal care and facilitating access to areas of the ward which were inaccessible otherwise as the patient was not able to open doors. This care was observed several times during our visit. In addition, it was pleasing to hear from the administrative staff that they saw an important part of their role as talking with patients and supporting them in whatever capacity they can as this can only contribute to a sense of holistic team working for patients. However, when patients were asked about engagement with other members of the MDT such as the occupational therapist and psychologist, there were no reports of meaningful activities taking place with one patient stating *"I don't think I saw anyone* [other than nurses or doctors]*"*. Patient feedback also showed a discordance between visibility and engagement from ward doctors. Several patients commented that while doctors made them feel involved in their care and decision making, they were not very active or visible outside of ward rounds, presenting a barrier to access. One patient also felt that their condition was not taken seriously enough by the ward consultant who did not listen to concerns they had raised and compared it with their care under a locum consultant who they felt much more favourable towards.

Staff visibility in patient areas was noted to be variable by volunteers which could be a reflection of the ward timetable. For example, during one visit we found that staff were in the office for a short time only during handover and were visible on the ward for the rest of the time. Whereas on our second and third visit it was noted that most staff were in the office or other areas with minimal activity in the main lounge area and at one point several patients or visitors queued by the nurses' station waiting for assistance.

Staffing levels

For hospital management, lack of sufficient staff numbers and shift pattern reductions were the most pressing concerns. We were informed there has been a recent change in the shift ratio for qualified/unqualified staff where the ward has changed from 3 qualified/2 unqualified on shift to 2 qualified/3 unqualified. This includes the introduction of Band 4 Assistant Practitioners which has been implemented to adapt to low recruitment and retention among qualified nurses. Assistant Practitioners are a relatively new role within the Trust (March, 2016) and are a new career pathway for experienced Band 3 Healthcare Assistants who have developed skills and knowledge from working within a specialist field for at least 2 years. This introduction is in line with national developments in the nursing

workforce and is designed to reduce reliance on a temporary workforce from chronic nursing shortages.

Night shifts typically run on 2 qualified and 2 unqualified. Patients and staff told us that staffing levels can appear deficient during night shifts. One nurse did not feel there were enough staff to manage the ward effectively. This staff member raised concerns that it took only one problematic patient to take up 2 staff members' time and attention leaving two others to oversee the ward. This staff member also told us this situation was exacerbated when there were unplanned admissions during the night which could result in more hurried care. Concerns about this were echoed by patients who said they felt at times like the ward needed more staff to ensure their needs are met.

Pressure can also occur when regular staff go on sick leave or a patient with special needs is admitted who requires extra staff. However, the ward manager felt the ward can easily counteract this as they do have access to a pool of bank staff who are familiar with the ward and can specifically request for these staff members when putting out bank shifts.

Staff Support & Training

Staff told our volunteers that overall morale on the ward is good and that colleagues remain supportive of one another despite an increase in perceived pressure on the ward. Staff were unanimous in feeling well supported by the ward manager and described him as being "wonderful", "special" and had particular praise for his open door policy. One bank nurse we spoke to who had been working within the Trust for 14 years also highlighted the good team work demonstrated on Lavender Ward, especially compared to other inpatient wards on site.

It was also encouraging to hear that all staff are aware of how to access training online and face to face sessions. The ward manager's positive and proactive approach is also reinforced to staff in that he is very supportive of staff training and development whereby staff feel encouraged to request additional training that is not necessarily mandatory but is suited to their professional interests. For example, the activities coordinator is currently being funded and granted time off to pursue an occupational therapy qualification. Mandatory training compliance is audited to ensure that staff stay up to date.

The ward consultant also spoke of the ever growing importance of safeguarding and confirmed that safeguarding adults and children is mandatory training for all clinical and nonclinical staff. With regard to overall staff support, the ward consultant said this was important to him and always aimed for the inclusion of staff as a professional standard and involves them in all joint consultant and nursing led decisions, for example ward rounds and patient appointment times. He also said he felt that efficient time management from medical staff has encouraged a good response and trust from staff.

Challenges Faced by Staff

Staff told us that challenges on the ward tend to vary day to day depending on the acuity of the ward. For example, it can feel quite pressurised if there is a cluster of new admissions. At times the ward can feel "unmanageable" according to one nurse and could benefit from higher staff numbers.

Bed blockages or delayed discharges remain the biggest challenge and hurdle in treatment planning. Discharging patients where input from social services is needed, especially concerning housing, has generally become very difficult for staff to negotiate as well as time consuming.

Outside of this, the ward consultant told us he thought patients and staff would benefit from not having as many as 23 patients on one ward but felt that the numbers were unlikely to change before the new unit is built.

Smoking Cessation

In preparation for the Trust's plans to become a site-wide no smoking zone in October 2017, staff said the ward has introduced a number of initiatives to transition and help patients adapt to this. Nicotine patches are now available to patients and staff are liaising with primary care when patients are discharged to ensure that patients on nicotine are followed up by their GP. Smoking cessation plans have also now been introduced as part of the patient's formal discharge plan. The ward manager also told us that 50% of staff have now received training in smoking cessation. Patients will be able to continue to use disposable vape pens when the ban comes into full effect. Two patients told us that they were concerned about the effect of the smoking ban on their wellbeing as smoking is an outlet for them while they are in hospital and highlighted they need an adequate alternative to compensate their need for smoking.

Outcomes Based Commissioning

At the time of our visit Outcomes Based Commissioning was a major driving force for change in mental health care in Richmond. Only one bank member of staff had heard of the term but did not understand the concept behind it. The ward consultant had little knowledge and felt it was a Trust matter that would filter down to him at the appropriate time.

Outcome

The aim of the Enter & View Visit was to capture the views and experiences from the patients, carers and staff on Lavender Ward and to observe the care and communication taking place on the ward and the quality of the physical environment.

Staff were largely positive in talking about their experience of working on Lavender Ward, with a strong consensus on overall morale being high. This was mainly attributed to good communication at all levels within the team and staff owning their roles and responsibilities. Sources of dissatisfaction in their job appeared to stem from external sources such as social services and bed management. The ward was mostly clean and well maintained with the exception of some minor maintenance work and waste removal in outside areas.

The actual care and communication style from staff was received very well by patients. Staff attitudes and their approach to patients also came across as very compassionate and empathetic in our observations. However, a lack of therapeutic activities in terms of number, variety, access to leisure activities and exercise undermined patient experience on Lavender Ward and made it difficult for patients to find ways of passing the time in a productive or beneficial manner.

Recommendations & Next Steps

After the visit, Healthwatch Richmond made a number of recommendations to the SWLSTG.

In response to the recommendations made in this report, South West London and St George's have put together a formal action plan to address some of the concerns raised.

The recommendations and the response from the Trust are summarised below:

Communication

1. We would like to see the ward introduce a system which reinforces the difference between a key nurse and daily named nurse to patients and the roles they play in their treatment and care.
2. We would also like to see the ward introduce a designated comments box in an accessible location on the ward as a confidential means for leaving feedback.
3. We would recommend a designated display on how patients can provide feedback once they have been discharged.

Response from SWLSTG:

1. *The name of each patient's key nurse is on a poster in each patient's bedroom. The ward manager will complete a monthly check to ensure each of the 23 bedrooms has a poster indicating who the key nurse is*

and what the patient can expect from the relationship. The role of the key nurse and the daily nurse will also be discussed routinely in the Community meeting.

2. *The Real time feedback machine is placed in the main living room of the ward and its use is promoted in the community meeting. The patient experience team has been asked to provide a report on patient feedback on a quarterly basis.*
3. *The patient experience team will produce a poster to advertise all methods patients can use to provide feedback. This will be placed in the main corridor and visitors' area. This will also be included as a standard agenda item in the ward's weekly Community meeting. At the point of discharge, all patients are asked to complete the Real time feedback machine.*

Care Plans

1. We would appreciate an update on what steps the ward has taken to ensure that care plans are done in full collaboration with the patient during their admission, so that patients and their carers are aware of all aspects of their treatment plan and how these are being implemented on the ward.

Response from SWLSTG

1. *The role of Care Plan Champion will be assigned amongst staff. A care plan audit will be conducted each month to measure the following:*
   - *I. Care Plan Distribution*
   - *II. Care Plan Quality*
   - *III. Service User Involvement*

The Modern Matron will oversee audit compliance and ensure 6 care plans are audited per month.

Patient Activities

1. Healthwatch Richmond strongly recommends adjustments are made to the ward's therapy programme so that it contains a greater variation to meet the needs of individual patients and include more outlets for patients to be creative.
   1.1 We believe an increase in the number of activities so they can be distributed evenly across the week would also benefit patients. Therefore, it was pleasing to hear that more staff were being trained to run activities. This should avoid certain groups being cancelled which has unfortunately been a previous pattern. We would like an update on how successful this training initiative has been.
2. We would appreciate an update on what alternatives have been set up to provide a means of physical exercise for leave-restricted patients who cannot take part in walking groups.

Response from SWLSTG

1. *The Modern Matron and ward manager will review the Occupational Therapy timetable jointly with the lead OT and ensure that activity coordinators are rostered to work across 7 days per week.*
2. *The ward will identify and purchase equipment suitable to support patients in undertaking physical activity within the courtyard of the ward.*

Ward Environment

1. We would appreciate an update on whether staff find the liaison with the PFI body satisfactory in responding to maintenance issues. We would suggest keeping a log to track the responsiveness to jobs being flagged as urgent
2. We would recommend a new rota for waste removal in the patio area or that it be factored into another cleaning rota
3. Have the ward introduced a system to ensure bank staff know where they can access information in case regular staff are not available to answer ad hoc patient queries?
4. To remove the risk of a ligature point from the TV in the female only recreational room and provide ease of access, we would recommend the TV be installed in secure see-through cabinet as utilised in other wards.

Response from SWLSTG

1. *The ward will set up a log to monitor responsiveness to maintenance issues which will be tracked by the ward administrator.*
2. *The ward will be smoke free from October 2017 which is expected to have a significant impact in the amount of waste generated in the patio area. This will be monitored so as to determine whether extra cleaning and waste removal rosters need to be increased.*
3. *No response provided*
4. *The ward manager and Modern Matron will order an appropriate cabinet to conceal any ligature points*
5. *The ward manager and Modern Matron will order an appropriate cabinet to conceal any ligature points.*

Meals

1. We would appreciate an update on what changes have been made to the menu or ordering process to ensure there is enough provision of fruits and vegetables for patients
2. We would recommend that a milk machine is installed to improve patient access to making hot beverages

Response from SWLSTG

1. *A representative from Sodexo to attend regular community meetings on request to provide an opportunity for patients to feedback about the food choice.*
2. *All wards have a supply of fresh milk provided. This is stored in the patient fridge which can be accessed both day and night freely.*

Discharge Planning

1. Healthwatch Richmond would appreciate an update on the progress in input from, and communication with social services
2. We would also be interested to know what extent are staff are now aware of the reconfiguration of social services in the Borough and how this has impacted discharge planning
   We would appreciate an update on how much of an issue remains around sourcing suitable accommodation in the community and its impact on delayed discharges.

Response from SWLSTG

1. *There are multiple causes of delayed discharges; obtaining accommodation is a significant one but is not the greatest cause of delays. The Trust suggests quarterly meetings with Healthwatch Richmond to share anonymised data on cases of Richmond residents who have experienced a long (60+ days) length of stay.*

Staffing

1. Healthwatch Richmond would like to see the introduction of a standard practice to ensure there are a minimum of staff out on the floor at one time
2. We would like an update on staff experiences of the shift change to 2 qualified/3 unqualified staff
3. We would also appreciate feedback on the rollout of Band 4 Healthcare Assistants and how this has influenced patient care and management of the ward

Response from SWLSTG

1. *Band 4 nursing staff are being trained currently. It is anticipated that this will free up qualified nurses from being within the office and allow them to be with patients. The ward administrator will be in the ward office full time so as to relieve nursing staff from taking calls. The ward administrator will take on tasks such as completing paperwork to support a patients discharge under the supervision of the ward manager which will further free up nurses' time so they can spend it with patients.*

2. *A safe staffing review has been undertaken in September which reviewed the levels of Qualified to Unqualified staffing. A consultation is currently underway in the Trust to reconfigure the staffing levels which includes the number of qualified staff on each shift.*

Smoking Cessation

1. We would like an update on how are staff and patients experiencing the impact of the site-wide smoking ban
2. Has the ward introduced any more initiatives to manage this?

Response from SWLSTG

1. *All smoking related incidents are being recorded on the ward to identify whether there has been an increase in the overall number of patient incidents*
2. *Lavender Ward will have designated smoke free champions to support the psychological aspects of being smoke free.*

Next Steps

Healthwatch Richmond will meet with SWLSTG in December 2017 to review initial progress and discuss what measures are being taken and to pick up on those areas where appropriate actions have not yet been identified.

The Trust has also suggested quarterly meetings with Healthwatch Richmond to provide feedback on the changes in social care in Richmond due the removal of social workers from joint management in the Trust, the shared senior management of Richmond social services with Wandsworth's and its impact on discharge planning from inpatient wards. Healthwatch Richmond plan to visit Lavender Ward in 3 months' time to review what steps and measures from the action plan have been implemented and whether they have achieved the desired outcome.

Healthwatch Richmond will also take up the issues raised about the separation of Social Services directly with Richmond Council and will endeavour to meet with senior managers before the end of 2017.

Acknowledgements

Healthwatch Richmond would like to thank the staff on Lavender Ward, Queen Mary's Hospital, Roehampton, for their cooperation and assistance with our visit and for making our volunteers feel so welcome on the ward. We would also like to thank the volunteers who have supported this project and undertaken the Enter & View Visits.

Appendix 1

Queen Mary's Hospital, Roehampton, Lavender Ward – Patient Interview Audit

Acute Adult Mental Health Inpatient Ward
WARD BASED ENTER & VIEW VISIT

Volunteer's Name ……. Date & Time Completed……..….2017

I am [*state your name*] from Richmond Healthwatch working in partnership with the Trust to speak with you about your experience of care and treatment during your stay here. Would it be OK if I ask you some questions about your experience of the hospital?

Please tick if patient agrees to this survey ☐

On admission, did staff tell you why you were admitted to the ward?
Did they give you information about the ward?
(If sectioned) Do you understand the meaning of the section that applies to you?
How quickly did you see a doctor to discuss your needs?
How involved to you feel in your care planning? Did your nurse go through your care plan with you?
Do you know what medicines you are taking? Are you getting them on time?
How are your wider healthcare needs being looked after (e.g. pain, smoking)?
How do you choose your food?

Appendix 2

Queen Mary's Hospital, Roehampton, Lavender Ward – Professionals Interview Audit

Acute Adult Mental Health Inpatient Ward
WARD BASED ENTER & VIEW VISIT

Volunteer's Name ……. Date & Time Completed……..….2017

I am [*state your name*] from Richmond Healthwatch working in partnership with the Trust to speak with you about your experience of working here. Would it be OK if I ask you some questions about your experience of the hospital?

Please tick if professional agrees to this survey ☐

What is it like to work here?
What are the challenges you face in providing good care?
How are you supported on a daily basis? Management supervision? Clinical supervision? Whistleblowing?
Do you know how to access training?
Are you trained in safeguarding? Do you know how to report abuse?
How do you involve patients in their care plan?
How do you access support for when a patient is discharged?
Has the Trust made you aware of the Outcome Based Commissioning for mental health?
How are relations with social services around patients' needs? Has this improved/deteriorated

Appendix 3

Queen Mary's Hospital, Roehampton, Lavender Ward – Carers Interview Audit

Acute Adult Mental Health Inpatient Ward
WARD BASED ENTER & VIEW VISIT

Volunteer's Name ……. Date & Time Completed……..….2017

I am [*state your name*] from Richmond Healthwatch working in partnership with the Trust to speak with you about your experience of care and treatment during your stay here. Would it be OK if I ask you some questions about your experience of the hospital?

Please tick if carer agrees to this survey ☐

What is your experience as a carer of dealing with the Lavender Ward staff? Have you any other comments?
Are you able to be involved in decisions about your family member/friend? If not, what is the problem?
How does the ward support you in caring for your family member/friend?
OTHER COMMENTS - Do you have any additional comments about the care? These comments are very helpful to us as we work to improve the quality of care provided to patients.

Appendix 4

Queen Mary's Hospital, Roehampton, Lavender Ward - Observational Audit

Acute Adult Mental Health Inpatient Ward
WARD BASED ENTER & VIEW VISIT

Volunteer's Name ……. Date & Time Completed……..….2017

Please Note: The observational audit must be completed at least 2 times per visit.

AREA OF PRACTICE TO BE AUDITED	**EVIDENCE PRESENT**		
Communication	**YES**	**NO**	**N/A**
What is the relationship like between the patients and the care staff? Why are they saying that?			
Are nurses and other staff engaging and clearly communicating with the patients?			
Are nurses and other staff attentive and responsive when spoken to by the patient?			
What are the commonest incidents on the ward and how are they reported?			
Staffing	**YES**	**NO**	**N/A**
Do there appear to be enough staff visible in patient areas?			
The Environment	**YES**	**NO**	**N/A**
Are the activity sheets clearly visible on the ward?			
Is the ward information available for those with language difficulties or with visual or hearing			
Is there a private area for discussion with patients and their relatives? (Ask staff)			
Is there a safe space for women to go, other than their bedrooms?			
How many single/double rooms are there on the ward? How many en suite?			
Can patients open/close the panels set into their bedroom doors?			