healthwatch
Central West London

Central and North West London NHS Foundation Trust - St Charles Centre

Dignity Champions' assessment of mental health services, Redwood Ward

July 2014

Table of contents

1. Executive summary

Healthwatch CWL is the consumer champion for better standards of care in health and social care services. Its team of Dignity Champions are volunteers recruited from the local community who work to improve standards of dignity in health and social care services. This report presents the findings of the Dignity Champions' assessment of the Redwood Ward at St Charles Hospital run by Central and North West London NHS Foundation Trust. Redwood is a mental health ward for older people. Several visits were undertaken by the Champions who recorded their findings based on their observation and interviews with patients and staff.

The Dignity Champions' findings highlight a lack of stimulation and interaction for patients who were often left to sit on their own or watch television. Recommendations relate to ways the ward could improve activities and staff communication with patients in order to support better recovery and mental wellbeing. The report also identified issues around the availability of drinking water for patients: this is another key recommendation. Other recommendations include improvements around nutrition, the environment of the ward and better involving patients in the care-planning process.

2. Introduction

In April 2013, Local Healthwatch was established under the auspices of the Health and Social Care Act and became the successor of the Local Involvement Networks (LINks).

Healthwatch CWL is the independent consumer champion for health and social care services and has over 5,000 members who share a passion for improving these services across the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster.

Our Dignity Champions' key priorities are to listen and understand the views and experiences of local residents, and to speak up about dignity to improve the way services are organised and delivered. The Healthwatch CWL Dignity Champions follow the 10 standards set out in the Department of Health's 'Dignity Challenge[1]'.

The Dignity Challenge

High quality care services that respect people's dignity should:

1. Have zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

[1] http://www.dignityincare.org.uk/Dignity_in_Care_campaign/The_10_Point_Dignity_Challenge/

3. Methodology

The Dignity Champions assessed the Redwood Ward at St Charles Hospital – an inpatient ward for older people with a variety of mental health needs.

The assessment was carried out using four methods:

1) Observation
2) Interviews
3) Conversations with staff members

1) The Dignity Champions recorded their observations relating to areas including the hospital environment, staff interaction with patients, mealtimes and patient privacy on the specially designed observation tool.

2) Interviews were conducted with patients who were happy and able to participate. These were recorded on the interview tool. Because of the mental health conditions of patients on the ward, some were not able to participate or could only complete portions of the interview. Five patients were interviewed during the visits while the Dignity Champions had informal conversations with several others.

3) Informal conversations were conducted with a range staff members on duty at the time of the visits.

3.1 Assessment dates

Assessments took place from July 10th to July 15th 2014, as follows:

- July 10th, 9.30am to 12.30pm
- July 11th, 1-4pm
- July 12th, 9.30am to 12.30pm
- July 15th, 1-4pm

4. Findings

4.1 Environment

The Dignity Champions scored the Redwood Ward on a variety of factors relating to its environment including décor, cleanliness, tidiness, odour control, noise levels and lighting. Overall, most Champions felt the environment of the ward to be either 'good' or 'average' with some areas scoring as 'very good' but no ratings of 'excellent'. There were, however several aspects of the environment that were rated as 'poor'.

Several Champions made negative comments about the entrance to the ward. One Champion felt it was inappropriate that staff were feeding patients near the entrance; another commented that there were a lot of patients sitting in the entrance area rather than lounge areas; someone else felt the entrance area was extremely busy and chaotic.

It was felt that there was room for improvement with the décor of the ward. One Champion described it as 'a bit sterile'. Another person felt the dining area and one of the lounge areas needed painting and the colours were dull; a newer lounge was felt to be 'more user friendly'. Other Champions felt more positive about the décor.

There were a couple of concerns regarding the tidiness of the ward. One Champion said dirty dishes were left in the dining area for several hours; another commented on 'lots of unnecessary things'. Some people rated cleanliness standards as good. Others raised concerns such as no hand dispensers for antibacterial soap on the ward. One patient thought the ward had a problem with mice and also pointed out dirty skirting boards to a Dignity Champion. The Champions observed dirty, stained bedding in one room. The net curtains were thought to need washing because of their grey colour and in one place they needed to be re-hung.

There were a couple of issues with odour on the ward: one Champion mentioned 'strong smells' in parts of the ward; another mentioned a smell of urine in one of the lounges. Another described the ward as smelling clean 'but quite warm and stuffy'. One Champion said the environment could be vastly improved by better temperature control and background music.

The Dignity Champions did not see a garden area. Apparently this is accessible from another ward. When asked about the outdoor area, some patients did not seem to know about it; one patient described it as 'nice' and said they got to go out in it 'sometimes'.

4.2 Bathrooms and toilets

Reports on the cleanliness of bathrooms and toilets were mixed. Some people observed them to be clean or even 'very clean'. However, one Champion reported that during their visit toilets were dirty with used toilet paper on the floor. Two people said the female toilets were clean but male toilets were dirty and had a bad odour.

4.3 Patient safety

Call bells were in place on the ward and seemed to be accessible to all patients. One Champion felt the system was quite noisy and disruptive as call bells were going off a lot of the time. Ward security was felt to be good with a buzzer system in place to let people in and out of the ward.

However, there were concerns regarding patient safety. Loose wires were noted in a lounge area hanging from a fan. The quiet room had cables dangling from a computer. One Champion said in general there were too many wires and plugs unprotected.

A cabinet used to store glass jars in a communal area was noted by several Champions. This was felt to be unsafe for patients owing to the potential dangers of broken glass.

Some furniture was out of place in a lounge area and patients were seen moving heavy furniture which was felt to be a risk.

The nurses' station was tucked around a corner with no clear view of communal areas and it was felt that patients were sometimes left unattended for too long. In one instance a woman fell asleep with her face in a chair kneeling on the floor in a lounge area and the Dignity Champions were concerned about suffocation and therefore alerted staff members. On another occasion a man fell asleep on the floor although staff did come to his aid.

4.4 Eating and nutrition

A sink was available for patients to wash their hands before mealtimes but during the first mealtime observed by the Dignity Champions no one seemed to be using it. A member of staff told the Champions that as patients were likely to have had a shower before the meal (breakfast) their hands would be clean and there was no policy of washing hands before the meal. However, at the following mealtime one Champion reported that patients were encouraged to wash their hands.

During the breakfast meal observed by the Champions, no napkins, trays or tablecloths were provided for patients. These were available during lunchtime.

The Dignity Champions felt there was a lack of meal choices for patients. Patients choose what they want to eat at serving time rather than in advance of the meal. Sandwiches are provided as an alternative to the main meal. One resident commented on the lack of a hot option for breakfast. Apparently special dietary requirements such as vegetarian and halal are catered for on the ward. One kosher meal was noted. However, one patient said she was often given foods she is allergic to. She said she had told staff about these allergies on a regular basis but nothing had been done. She said her hands were swollen owing to eating the wrong kinds of food.

Reports of whether patients were receiving the assistance they needed to eat were mixed. During one mealtime, the Champions felt most people were able to feed themselves. At another those requiring help were indicated by a red table mat. One man was being helped to eat but was apparently angry about it. It was unclear whether the manner of assistance was making him angry or something else. One staff member was standing over a resident, spoon-feeding him.

Several Champions commented that patients were left unsupervised during mealtimes. Social interaction was almost non-existent between patients. People were eating alone and there was almost no engagement. One Champion felt music might have helped create an atmosphere. The presence of staff might also have helped to stimulate conversation.

The appearance of the meal was generally described as unappetising by the Champions. Descriptions included 'bland', 'undercooked', 'processed' and 'not very appetising'. One

person said it looked ‘eatable’. Another Champion commented on ‘over-full plates’ which looked messy. One Champion said the meal was dished out ‘without much love’.

Reports as to the availability of fresh fruit and vegetables were mixed. At one meal patients had pears and bananas; at breakfast time apparently no fruit was available. One Champion commented on ‘stewed looking beans’ and a banana being offered. One Champion said fruit was not readily available although one resident got a banana on request.

In general patients seemed to have enough time to eat their meal. However, one Champion commented the room was ‘so stiflingly hot’ during one mealtime that patients did not hang around.

One incident was noted during which a man was given his meal, went off for a walk and it was taken away. He was not given anything else to eat. One Champion felt patients’ food intake needed to be more closely monitored.

4.5 Water and drinks

Water dispensers were noted at each end of the ward. However, one had no cups during one of the visits. Availability of drinks at mealtimes seemed inconsistent. At one mealtime there were no jugs of water on the table and patients had to request it from staff. At another mealtime water and squash were on the table.

On one occasion a resident asked for tea but was refused being told ‘now is dinner time’ by server.

One resident reported having to ‘beg’ for cold water the day beforehand and said they were ignored by staff. The person said ‘afterwards they gave me warm water and I felt sick.’

Another patient said they had started carrying water round in an empty juice carton so they did not go thirsty.

4.6 Activities

Activities were cancelled during the Dignity Champions visits. One commented that the range of activities supposed to be on offer (displayed on a board) was ‘poor’ anyway with ‘TV in lounge’ as an option on several occasions. One Champion said the activities were listed in small print and were not appropriately explained. The activities coordinator was apparently not around.

On one occasion a ‘Moving Forward Group’ was supposed to be taking place but the room it was scheduled in was locked.

Patients seemed to have the option to have time on their own if they wished to. One Champion described the ward as quiet and said people are able to wander around or sit

quietly. The problem was the amount of time people were spending on their own with a poor ratio of patients to staff and minimal engagement.

Patient reports about whether they could choose what activities to take part in varied. One person said they were able to choose and cited drama and reminiscence as examples. Another person said no one ever asks what she wants. Another said no they do not get asked what they would like to do. On patient said activities are written on the board but Saturday (the day of one of the Dignity Champions' visits) was a day off. This person said they took part in drama, music and art therapy.

One patient said there is not enough to do and most of the day they watch television. Another also felt there was not enough to do and said 'we only do activities once or twice a week' and said one of these is walking about the ward.

One patient said they like sitting in the entrance area but staff think it is not good because you are staring into space. Another said they sit in the entrance because other rooms are too hot.

4.7 Staff and communication

It was felt there were not enough staff members to attend to the patients on the ward. One Champion felt it varied from one end of the ward to another. Another felt there were lots of 'blind spots' on the ward.

Reports of staff interaction with patients varied. One Champion said there was very little interaction. Another Champion described staff body language as 'stressed, busy' or 'poor – defensive'. Others gave more positive reports of 'open, helpful' body language' and 'good, calm, open, positive' body language. One Champion felt staff were 'caring but possibly overworked'. One Champion said only one staff member seemed to engage with residents.

There were some reports of staff members speaking to patients 'clearly, slowly and appropriately' or 'quite kindly'. However, one Champion reported an incident where a staff member shouted across the room at a patient about cream for her skin in front of other patients. Another incident was reported where a patient was distressed and was seen slamming things and shouting. This person was guided into a room and told to sit quietly, staff would return in ten minutes. However, no one returned for 35 minutes. There were several reports of patients not receiving engagement from staff, again with residents often sitting alone in the entrance area.

Patients mostly felt that staff were patient with them. One patient did not think so, saying 'no, never'. One patient said there were two reliable male nurses but felt some of the female nurses were not so reliable.

One patient said they would like 'a little more' interaction with staff and said they are often left to sit on their own. Another patient commented that staff talk to each other a lot 'about their own interests'.

It did not seem that staff had got to know individual patients particularly well. One lady laughed when asked about this and said she did not think the staff had tried to find out about anything that mattered to her. Another person when asked if staff had got to know them said 'not much'. Someone else said 'they know me, I have been here before.'

In terms of whether staff asked patients for their feedback, one patient said no, 'the staff never speak to me'. Another was not sure. Another said they are asked by they choose not to answer because 'you have to be careful about what you say'.

When asked whether staff listen to their needs and wants, one patient said 'to an extent' and said there was an advocate who visits. Another said no 'they do not ever listen to what I have to say'. Another said no and gave an example where she had needed to clean her feet but could not reach. She was apparently offered a shallow pan of water to wash them herself, which she reported but was told it was not the staff's job to help. She said she does not ask for things anymore.

Most patients felt their privacy was respected by staff members. One said 'some are good with knocking before entering my room'; another said their privacy was respected 'most of the time'.

All patients were called by their preferred name.

4.8 Care planning

Only one patient interviewed was aware of having a care plan. One patient said 'I know the word care plan and everyone should have one but I have never seen mine'. Someone else said 'they haven't really made one'. Two other people said 'not sure' when asked about their care plans.

One person said they did have a meeting with staff to plan their care. Another said they had never had such a meeting. Someone else said they had been on the ward for seven months and have not had a meeting to plan their care. Another person was not sure.

Only one person felt they had been offered information and choice about the treatment they had received. One person said no, 'they just do it'. This person did not like injections but said she is forced to have them. She had apparently asked for oral medication but had been refused. Two others answered 'no' to receiving information and choice about their treatment and two people declined to answer.

Three patients interviewed together said they did not want to take medication but were being forced to take it. One said 'if you've been sectioned staff say you have to take meds – they force you/trick you.'

One person had complained about being held down by 5-7 staff to be given an injection once a month.

4.9 Discharge

None of the patients interviewed were aware of having their discharge discussed with them. One person said discharge had not been discussed during this stay but had been during their last stay. Another said no 'but I feel the doctor would do when I'm ready to go home in a few weeks'. One said no – they had a meeting planned that week but did not know what it was for. Another said no, they were not sure how long they would be there for.

Patients were generally not aware of receiving any information about support during or after discharge although one person referred to two long-term carers they had outside the hospital. Another referred to a befriender, music therapy and home care visits.

When asked whether they had opportunities to mix with other residents and keep in touch with friends, only one patient said yes. One person said she had time to go out unassisted but didn't because the medication makes her tired. Another said 'I don't see people very often from outside and staff don't spend much time with us.' Others did not answer.

4.10 Complaints

When asked whether they would know how to complain if treated badly patients responses varied. Two people said they would tell an advocate. One said 'I would tell some of the staff'. Another said 'just would stay quiet' or 'go to the manager'. Someone else just said yes, they would know how to complain.

As to whether they would feel comfortable complaining, four people said yes. One specified to an advocate, another specified by telling staff. One person said no, they would not like to complain 'in case there are repercussions'.

When asked whether they had had any issues with members of staff, one patient said that previously a staff member had forced them to have a shower. The patient had complained but the staff member had then reprimanded her. She then spoke to an advocate and there had been no problems since.

4.11 Improvements

Patients were asked whether there was anything the staff or service could do better. These were some of the responses:

- 'Give us more free time. More trips. Outside these four wall confines.'
- 'Food. Staff shouting at patients.'
- 'Staff keys always jangling, more interaction…'
- 'Ask if we would like a drink more often. TV remote is put in a drawer in desk at reception – we don't get to change channel or volume (often too high).'

Patients were also asked whether there was anything they would change about the ward.

- ‘Dietary requirements. Food, temperature control, background music.’
- ‘Other than over-medication it all seems fine.’

5. Conclusion

In general the patients on Redwood Ward appeared to be lacking in stimulation with not enough staff to oversee and interact with them, a lack of activities on offer and little opportunity to interact with friends, family and the wider community.

There were some positive reports about staff but patients did not seem to have the one-to-one interaction important to aiding recovery from mental illness. This may have been due to the ward being understaffed. At mealtimes and in communal areas little interaction was witnessed and with scheduled activities cancelled opportunities to facilitate interaction among patients were being missed.

The lack of staff was also perceived as putting patient safety at risk with some patients left in inappropriate situations without proper supervision – whether it be falling asleep face down on a sofa or on the floor, or being left alone in a room after a disruptive incident.

The quality of food could be improved and the nutritional requirements of patients could be better met with greater availability of fresh vegetables and fruit, more meal options and better awareness of dietary requirements. Again the opportunity for patients to socialise with one another and for staff to interact with patients seemed to be missed during mealtimes.

Patient reports suggested they were not involved in care plans and in making choices about the treatment they received. Perhaps patients would be more in favour of taking medication if they had more information about it and felt more involved in their care planning process.

Improvements could be made to the environment of the ward to make it a more cheerful, inviting and atmospheric place to spend time, which would perhaps also promote patients’ wellbeing and recovery. Several areas in which safety could be improved were identified.

6. Recommendations

Environment

6.1 The hospital should look at re-decorating parts of the ward to make them brighter and more inviting. Net curtains should be washed and re-hung, skirting boards re-painted where necessary and dirty bedding washed as soon as possible.

6.2 Dishes should be cleared from the dining area straight after each meal.

6.3 Soap dispensers with antibacterial should be introduced throughout the ward.

6.4 Better ventilation to combat bad odours and stuffiness should be explored, e.g. opening more windows.

6.5 The ward should look at the possibility of background music to improve the atmosphere on the ward.

Bathrooms and toilets

6.6 More regular checks of bathrooms and toilets should be introduced to improve cleanliness and hygiene standards.

Safety

6.7 Loose wires should be secured and plugs protected.

6.8 The cabinet containing glassware should be relocated or locked up.

6.9 Staff should perform more regular checks around the ward to ensure patients are safe.

Eating and Nutrition

6.10 Hand washing should be encouraged before mealtimes to minimise risk of hospital infections spreading.

6.11 Make sure napkins are available at all mealtimes.

6.12 More staff should be present at mealtimes to support those who require assistance, oversee everyone and to talk to patients.

6.13 Ensure assistance with eating is given with sensitivity and discretion and patients are asked first of all.

6.14 Consider introducing different portion sizes and improve the presentation of food.

6.15 Make sure fresh fruit is available to everyone at mealtimes.

6.16 Ensure patients' dietary requirements are taken into account and that food intake is monitored to ensure no one goes hungry.

Water and drinks

6.17 Make sure water dispensers always have cups. Ensure jugs of water are always on tables at mealtimes and patients are offered help to pour themselves a drink.

Activities

6.18 Review activity programme to ensure it is stimulating, diverse and reflecting the needs of patients. Best practice guidance for mental health services by the Carers Trust suggests 'the range of activities should include occupational therapies such as art and craft, yoga and quizzes, as well as ordinary simple indoor and outdoor activities such as preparing food, reading in the library, and gardening.[2]'

6.19 Make sure there are activities on a daily basis and that these activities are not cancelled unless absolutely unavoidable. The National Institute for Clinical Excellence (NICE) recommends that 'people in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.'[3]

6.20 Ensure the activity programme is clearly displayed and explained.

6.21 More trips outside the ward should be introduced and the outdoor space at the hospital should be used more often.

6.22 Staff should spend more time interacting with patients and finding out about them as individuals. The introduction of volunteers to spend time with patients should also be considered. A report by the British Association of Psychiatrists emphasises the importance of one-to-one interaction for patients on mental health wards:

> *One-on-one interaction on a daily basis is key to reviewing patients' health at its broadest level and to providing the listening time that patients value so highly. Disturbed and erratic behaviour can also be minimised with regular one-on-one sessions*[4].

Care planning

6.23 Ensure all patients are involved in the creation and revision of care plans as much as is possible, along with family or friends where appropriate. Regular care planning meetings should be used to review care and also to get feedback from patients about their experiences on the ward. A report by the National Institute for Clinical Excellence

[2] http://professionals.carers.org/health/articles/triangle-of-care,6802,PR.html
[3] http://www.nice.org.uk/guidance/QS14
[4] http://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf

(NICE) recommends that 'people using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it'[5].

6.24 Make sure that patients are being forced to take medication only as the absolute last resort and when this is necessary it is done in the most sensitive and caring way possible. The National Institute for Clinical Excellence (NICE) has guidance for this:

> *People in hospital for mental health care [should be] confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force*[6].

Discharge

6.25 Discuss discharge with patients at the earliest possible opportunity so they have an idea how long they will be spending at the hospital and are well-informed about the support they will receive during and after discharge.

Complaints

6.26 All patients should be informed of the complaints procedure and reassured they can make complaints without fear of repercussions if they need to. Complaints should be followed up with the patient so they know how they have been dealt with. Learning from complaints should be displayed in a positive manner on the ward.

Improvements

6.27 Ensure patients get to have a say about what they watch on the television and that the volume is at a reasonable level.

7. Contact details

Mel Christodoulou

Healthwatch Westminster

Melanie.christodoulou@hestia.org

Ph: 0208 968 8984

[5] http://www.nice.org.uk/guidance/QS14
[6] http://www.nice.org.uk/guidance/QS14