West London Mental Health NHS Trust

Hammersmith & Fulham Mental Health Unit Spot Check

(Avonmore Ward and communal areas)

Dining area, H&F Mental Health Unit

1. Introduction

Healthwatch Central West London supports members of the local community who share a passion for improving and changing health and social care services within the three boroughs.
Healthwatch Dignity Champions aim to empower service users to make sure they have a voice in the design and delivery of health and social care services received. The 'Champion' role involves raising awareness amongst patients and the community about basic standards of care, conducting assessments of local health and social care services, implementing the 10 standards set out in the Department of Health's 'Dignity Challenge' and most recently carrying out follow-up 'spot-checks' of services.

The Dignity Challenge

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

1. Have a 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.

The Dignity Champions' work began in Kensington & Chelsea in 2010. Nutrition for older people had been identified as a local priority and the first assessments looked at dignity in care and nutrition for older people in residential care homes and hospitals. The work of the Dignity Champions has now branched out to include a range of other local health and social care services, including home care services, learning disabilities services and day centres. It is no longer limited to older people although their wellbeing remains an important focus.

2. Previous assessments of Hammersmith and Fulham Mental Health Unit – August 2012 and March 2014

The Dignity Champions first visited the Hammersmith and Fulham Mental Health Unit in August 2012[1]. More recently, we visited in March 2014, at which time the Champions carried out a full assessment of four wards over six visits as follows:

The Dignity Champions' overall impression of the unit in March 2014 was summed up as follows:

[1] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/HF-MH-Unit-WLMHT0314.pdf **See pg 15 onwards**

The Dignity Champions made positive reports about the improvements to the environment of the WLMHT H&F Mental Health Unit on the Charing Cross Hospital site. Avonmore Ward in particular, and the bathrooms and toilets in general, need some attention but overall standards seemed okay. Reports on food seemed satisfactory with some room for improvement. The Unit could look at what changes need to be made so more patients enjoy the food rather than just finding it 'okay'. Most patients seemed happy with the range of activities on offer and felt there was enough to do on the unit during weekdays.

However, Dignity Champions had cause to refer four incidents reported to us to senior management and the local safeguarding team for follow up. It seems that there are a number of problems in the way some staff members communicate with patients and this needs to be addressed. Reports of staff shouting and swearing were of concern to the Champions. Overall, it appears staff members could make more of an effort to get to know patients as individuals. Another key area for improvement is patients' ongoing involvement in the care planning process and in having their say in their treatment. Patients also need regular opportunities to provide feedback in both an individual and in a group setting.

The Dignity Champions made several recommendations to West London Mental Health NHS Trust for areas where improvements could be made. They were as follows:

Bathrooms:

1. Ensure regular rota for cleaning and checking bathrooms and showers. Ensure any mess/damage such as broken toilet seats are addressed straight away.

2. Look at whether plumbing work needs to be undertaken if toilets are blocking on a regular basis and this is preventing patients from using the showers as well.

3. Communicate alternate arrangements and provisions clearly to patients.

Safety:

4. Look at areas of the unit where greater risk management may be required to prevent fights breaking out between patients.

5. Look at the training needs of staff around physical intervention including restraint and review the effectiveness of the current policy and practice.

Eating and nutrition:

6. Ensure food is served at the correct temperature.

7. Give patients an opportunity to provide feedback on food and mealtimes so that areas for improvement can be identified.

Patients' wellbeing:

8. Review times and lengths of smoking breaks.

9. Look at whether the public telephone could be put in a more private place or perhaps a cubicle area fitted so that patients can have private phone calls.

10.Review storage facilities for patients belongings in bedrooms.

11.Review financial arrangements for patients and the accessibility of the bank.

12.Ensure patient medication is reviewed regularly and communicated clearly to all stakeholders. Review policy and practice on medicine management also.

13.Ensure all staff wear name badges including trainees.

14.Review personal development and performance management planning sessions with staff and hold regular supervisions to address the patchy implementation of practice by staff.

15.Hold 'board to ward' sessions to ensure management are leading by example and embedding an appropriate culture on the Unit.

Staff and communication:

16.Ensure all staff communicate with patients in a respectful and calm manner. Whereas some staff members are clearly doing a very good job, those who are shouting or swearing at patients need to be identified. Patients should be informed of how to make a complaint about a staff member if they need to.

17.Encourage staff to get to know patients as individuals and find out about the things that matter to them.

18.Look at whether patients need to be disturbed by lights going on for checks at night-time.

19.Make sure people have a choice about the gender of their GP, nurse and support worker.

20.Ensure everyone is asked for their opinion about the services they receive on a regular basis - both through individual and group meetings - and use this feedback on an ongoing basis to improve the service. The Meridian i-pad system should be repaired or another alternative for gathering patient feedback considered.

21.Re-visit the impact of the plastic box cubicle for staff on Avonmore Ward.

Care planning:

22.Ensure every patient has access to and is involved in creating their own care plan, with support from family members where required. Ensure patients are well-informed about their treatment options and involved in decisions

through regular meetings with staff members.

Discharge:

23.Review the discharge policy and practice on the Unit.

24.Make sure all patients are informed about discharge arrangements as soon as possible after admittance. Ensure they are involved in decisions about support to be given after discharge takes place and that they feel happy and comfortable about these arrangements.

25.Provide a user friendly leaflet on discharge to patients to support their planning and ensure a multi-disciplinary approach is taken include physical health and social and/or community supports.

26.Provide patients being discharged with a summary including key point of contact, what to do in a crisis and any follow-up activities.

Complaints:

27.Provide all patients with clear and accessible information about how to make a complaint as soon as they are admitted. Make sure patients feel reassured that they will not be treated differently for making a complaint.

28.Ensure all patients are also aware of the advocacy service and that staff engage with the service to act on regular feedback.

The findings of the original assessment were taken into account by the Dignity Champions when performing their spot check.

The Dignity Champions perform spot checks on local health and social care services they have previously assessed and reported on. This enables us to follow up on previous recommendations and also to perform an unannounced visit to gain a snapshot of the service on an average day. The provider is given some warning that a spot check will occur but not given a specific date. In contrast, when a full-scale assessment is undertaken by the champions' approximate dates are arranged with the provider for practical purposes as the champions often spend several days at the service.

In the case of the Hammersmith and Fulham Mental Health Unit, the Champions chose to focus their spot-check on two wards, Avonmore and Ravenscourt, and chose to visit in the evening. We had also received recent feedback from an inpatient on Avonmore requesting a visit. Due to the serious nature of this feedback, we raised an alert via the local safeguarding team.

2.1 Spot check of H&F Mental Health Unit

The Dignity Champions carried out their first spot check of Hammersmith and Fulham Mental Health Unit on Wednesday, the 4th February 2015. This was eleven months after the previous full assessment. The unit was notified at the beginning of February of a proposed spot check but specific dates were not given.

Dignity Champions were pleased to see that improvements have been made to the environment since our last visit in March 2014. However there were still a number of significant concerns, particularly around the quantity and quality of staff interaction and communication with patients, as such we have the following recommendations:

1. Ensure that regular audits are completed to identify cleaning and repairs that are needed and ensure they are completed in a timely manner.
2. Ensure staff are allocated the time and encouraged to communicate positively with patients.
3. Work collaboratively with patients to create a warmer, more homely environment at the unit.
4. Ensure, monitor and report on the involvement of all patients in writing their care plans and are aware of their contents and how to access them.
5. Ensure that discharge planning begins with patients as soon as they are admitted and ensure all patients are aware of what support will be available post discharge. Please see the emerging recommendations from the Healthwatch CWL work on the national Special Inquiry on Unsafe Discharge: Mental Health briefing[2].
6. Ensure everyone is asked for their opinion about the services they receive on a regular basis – both through individual and group meetings – and use this feedback on an ongoing basis to improve the service. As we flagged twelve months ago[3], the Meridian i-pad system should be repaired or another alternative for gathering patient feedback considered.
7. Consider an alternative serving arrangement at meal times to avoid long queuing times.

As Healthwatch has been flagging concerns about staff patient/interaction and about care planning for nearly three years (August 2012), as the Trust is relatively unique locally in not inviting external representatives to participate on their quality structures and as beds are closing in the Unit, we carried out a further spot check in May 2015.

3. The methodology

The spot check was carried out using three methods:

1) Observation
2) Interviews with patients (during the spot check we spoke to 6 patients)
3) Informal conversations with staff members

4. The findings

The dignity champions visited Avonmore Ward and the communal dining area, and were able to sit in on the weekly group meeting between residents and the mental health professionals who worked on the ward.

4.1 Environment / Bathrooms

Overall, dignity champions felt that the appearance and ambience of the ward had improved since the last visit. The wards appeared to be less clinical, more homely well and brighter. There were leaflets on the wall such as information about the Care Act, and a space for patients to provide feedback.

[2] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/191214-Special-Inquiry-Mental-Health-Briefing.pdf
[3] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-Central-west-London-response-to-the-West-London-Mental-Health-Trust-quality-accounts-2013-PAPER-6.pdf

However, although the ward appeared calm at the beginning of the visit, a number of patients said the ward is too noisy. At one point during the check, one of the residents became very loud and distressed.
Patients are able to share a communal TV area and an outdoor smoking space, but one resident stated that she felt as though she was '***a prisoner***.'
Dignity champions also noticed that the laundry room was extremely cluttered.

4.2 Safety / Patients Wellbeing

The main entrance to the wards was secured and Dignity Champions could not enter without assistance from the receptionist. At the time of our check, the garden was closed off so patients couldn't leave unless it was through the main entrance.

In contrast with our previous visit, at which time patients stated that they largely felt safe on the unit, numerous patients expressed concern over their safety on the ward during both our interviews and the group meeting we observed. One patient said '***there are lots of emotional patients, tears, fear, and there's nowhere to escape to***.' During the ward meeting, it was mentioned that five or six patients had recently been attacked by other patients. The same patient went on to say that the only place that she felt safe was '***in the bathroom, with the door locked.'***

Patients raised concerns regarding a lack of safety due to their bedroom doors having no locks, which a patient believed had also resulted in theft. One lady described a new patient as '***looking petrified.***' A patient from Lillie Ward whom the Dignity Champions spoke with in the dining area said checks are carried out every hour, which doesn't leave much time for privacy.
Another patient explained how she requested a duty doctor to visit the night before, but this did not happen, with reasons unexplained.

4.3 Staff and Communication

Previous feedback given about patient/staff interaction had raised concerns for Dignity Champions, and little interaction was observed during our spot check.

Whilst speaking to patients, it was found that staff members make little effort to engage with patients, with people stating they '***don't listen***,' and believing staff involved themselves in other activities such as '***doing something on the computer.***' This patient also told us about an incident that occurred where a staff member mocked a patient who discussed her dream.

During an interview in the communal dining area, one patient discussed how some staff members are '***amazing and lovely***,' and others '***impatient***.' When asked if she had had any issues with staff members, she responded with '***no comment, I don't want to complain.***' This was particularly concerning as she followed up by stating that she had been treated differently after a previous complaint.

Although people reported having discussed their care plans, one woman explained that the staff members do not take an interest in the patients' general wellbeing. In her experience and in comparison with other mental health units, there is very little interaction between staff members and patients.

We observed that in the communal area in Avonmore Ward, staff members sat in a separate booth. The booth was closed off by a large, glass window, causing a barrier between staff and patients and creating an 'us' and 'them' atmosphere.

Dignity Champions did feel encouraged by feedback from one patient who discussed the usefulness of regular group meetings, and the gradual changes being made.

4.4 Care Planning and discharge

Only one patient discussed discharge. She explained that she was waiting for accommodation and that was the ***'only good thing'*** staff members had been involved in.

4.5 Activities

Dignity champions did not observe any sign of regular activities taking place in the ward. During an interview, when asked if the patient could decide which activities she would participate in, she responded by saying '***I don't know what's going on, they don't tell us anything,***' and explained that the only thing to do in the ward was watch TV, smoke and go to sleep. Another resident did know of activities that happen in other parts of the Unit and that she had been invited to go to but chose not to attend.

Engaging with the group meeting provided Dignity Champions with a greater insight on the activities available. The group discussed how the weekly meditation group 'Mindfulness' was being put on hold temporarily, which was a cause of distress for some patients. One woman explained that it was the only thing that she looked forward to, and was the only form of therapy she received.

Group participants also explained the need for a counsellor. Magazines were requested for the Ward. However, health professionals said that this was a difficult to meet as the magazines are often taken away and not returned.

5. Recommendations

Dignity Champions were pleased to note some improvements had been made to the environment since our previous visit in February 2015. However, there are still a number of significant concerns, particularly around the quantity and quality of staff interaction and communication with patients, as such as have the following recommendations:

1. Ensure staff are allocated the time and encouraged to communicate positively with patients.
2. Work collaboratively with patients to create a warmer, more homely environment at the unit.
3. Ensure, monitor and report on the involvement of all patients in co-writing their care plans and ensure they are aware of the contents, outcomes and how to access the detail.
4. Ensure that discharge planning begins with patients as soon as they are admitted and ensure all patients are aware of what support will be available post discharge.

Please see the emerging recommendations from the Healthwatch CWL work on the national Special Inquiry on Safely Home[4]

5. Ensure everyone is asked for their opinion about the services they receive on a regular basis – both through individual and group meetings – and use this feedback on an ongoing basis to improve the service. As we flagged twelve months ago[5], the Meridian iPad system should be repaired or another alternative for gathering patient feedback considered.
6. As Healthwatch has been flagging concerns about staff patient/interaction and about care planning for nearly three years (August 2012), and as the Trust is relatively unique locally in not inviting external representatives to participate on their quality committee, we would strongly encourage the Trust management to meet with Healthwatch CWL on a regular basis to ensure these recommendations are implemented now in an effective and timely manner.

6. Contact

For further information or to request this report in an alternate format, please contact:

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[4] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/170715_healthwatch_special_inquiry_2015_0-2.pdf
[5] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-Central-west-London-response-to-the-West-London-Mental-Health-Trust-quality-accounts-2013-PAPER-6.pdf