Gwynne Holford Ward Enter & View Report

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

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Date of Visit: 14 December 2016

Published: 29 March 2017

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Introduction

Healthwatch Richmond undertook visits to Mary Seacole Ward at Queen Mary's Roehampton on 20th of April 2016 and 23rd November 2016. The first visit was in response to concerns received from patients, relatives and the community about the quality of care on the ward. The second visit was to explore the provision of ward based activities, care planning and discharge procedures. In undertaking this work it became clear that there was some uncertainty as to whether the patient reports related solely to the Mary Seacole Ward or whether some also emanated from the Gwynne Holford Ward, the neurorehabilitation ward at Queen Mary's Hospital.

During this process the Care Quality Commission (CQC) inspected St George's Hospital's Community Health Inpatient Services of which the Gwynne Holford Ward is part in June 2016 and it received an overall rating of "INADEQUATE". Specific concerns were highlighted for patient safety, staff shortages, and the implementation of Deprivation of Liberty Safeguarding (DoLS) regulations, incident reporting and medical assessment of deteriorating patients. However the services were described as providing compassionate care and there was excellent multidisciplinary team working. For more details see Appendix 2 and the CQC Report at:

Queen Mary's Hospital Community Health Inpatient Service

Therefore, Healthwatch Richmond made a decision in September 2016 to undertake an Enter & View Visit to the Gwynne Holford Ward to explore the standards of care on the ward and to hear the views of patients, relatives and staff.

Background Information

St George's University Hospital NHS Foundation Trust's neurorehabilitation services provide specialist care not available at other hospitals or in the community from across Southwest London and the Home Counties at St George's Hospital, Tooting and Queen Mary's Hospital, Roehampton.

The service provides specialist neurorehabilitation to patients who require intensive therapy following acquired neurological conditions resulting in physical or psychological disabilities. This includes patients who have had strokes, traumatic injuries to the brain or spine, anoxic brain damage, diseases or infections of the nervous system, and long-term conditions like multiple sclerosis. Services are provided on an inpatient or day patient basis. They also provide a range of assessment and diagnostic clinics and advise on the care of patients at other treatment centres.

The comprehensive treatment service is provided by multi-disciplinary teams to address patients' needs and maximise their recovery. The teams include nurses, occupational therapists, physiotherapists, social workers, speech and language therapists, medical staff and clinical neuropsychologists. The service also has consultants in neurology, stroke medicine, rehabilitation medicine, neuropsychiatry and clinical neuropsychology, as well as doctors in training. Other professionals e.g. from Psychiatry may be asked to join the treatment team should their input be necessary. The Gwynne Holford Ward is part of the

Wolfson Neurorehabilitation inpatient service based at Queen Mary's Hospital, Roehampton.

Inpatients are admitted for an approximately 12 week programme and follow individually tailored programmes based on goals set by the patient and their family or carers, in collaboration with the treatment team. Close liaison is maintained with families, carers and community services, including statutory and voluntary organisations, to help patients' progression from the inpatient setting to the home environment.

Day patient and outpatient services include the Vocational Rehabilitation Programme which helps neurological patients back into employment, through a tailored approach in individual and group settings. Support groups for patients and their families are also available. The team provides assessment, guidance and support, helping clients regain their confidence.

The age of the patients ranges from 18 – 90, with a mean age of 40 – 60 years. Elderly patients who are admitted, usually for therapy after a stroke, tend to be high functioning and dementia is not normally present. Approximately 40% of patients have had a traumatic brain injury and 40% a stroke

Further information is provided in Appendices 1 and 2 and more information is available on their website:

St George's Hospital - Gwynne Holford Ward

Admission Routes and Patient Referrals

The patients on the Gwynne Holford Ward are funded by 10 Clinical Commissioning Groups and NHS England. There are two categories of patients according to a national NHS Standard. Category 1 patients are usually on the ward for 12 weeks or more and Category 2 patients for 8-12 weeks. The latter are usually referred by their GPs or therapists.

There is a Multidisciplinary Team assessment of the patient before they can be admitted and the waiting list is determined by the level of the patient's needs. It is not a 24/7 acute medical service and patients who require this level of input can be accommodated in beds at St George's Hospital if necessary.

Gwynne Holford Ward Structure

During the last year a number of changes had been made to the layout of the ward in response to both staff shortages and the CQC Inspection of June 2016. As the ward occupies 2 floors they have tried to ensure time is not wasted moving patients around unnecessarily and thus reducing the staff time needed.

Currently the lower floor houses the ward beds, the large gym and kitchen. Keeping all the nursing activity to this one floor maximises patient safety and we were told this was working well.

The upper floor has the therapy rooms, activity areas, a lounge and gym. This floor is also used by the day patients.

Aim of Project

The aim of the Enter & View Visit was to gain a better understanding of:

1. The current patient experiences on the Gwynne Holford Ward at Queen Mary's Hospital, Roehampton
2. The issues and concerns that had been raised with Healthwatch Richmond from a number of sources in 2015 and 2016
3. The issues raised by the Care Quality Commission Inspection of June 2016

What We Did

To understand the existing data on the services offered by the Gwynne Holford Ward Healthwatch Richmond reviewed the complaints, concerns and comments received during 2015 and 2016.

We also reviewed the findings of the CQC Inspection of June 2016 which related to the Gwynne Holford Ward.

Questionnaires used for the Mary Seacole Ward Enter & View Visit of April 2016 were revised to reflect these findings and the different setting. From this work an Observational Audit was developed to be completed by the Healthwatch Richmond volunteers (Appendix 3) and a Qualitative Interview Audit for the volunteers to undertake with the patients (Appendix 4).

Methods

Healthwatch Richmond staff members met the senior nursing staff responsible for the Gwynne Holford Ward in October 2016 to discuss the purpose of our Enter & View Visit and to learn more about the ward, the patients and staff and make arrangements for the visit. The hospital welcomed our visit and was proactive in helping with the arrangements. A visit date of the 14th of December was agreed. Posters advertising our visit were displayed for a number of weeks before the visit and our leaflets and newsletters made available for patients and staff.

Healthwatch Richmond selected a team of six, three volunteers and three staff members, five of whom had experience in hospitals, nursing and or rehabilitation. The team met to review the background information, develop the questionnaires and plan the structure of the visit.

On the day of the visit we were welcomed by the Head of Nursing for Neurological Sciences at George's Hospital, and a range of senior staff for the ward and the service including: Ward Matron, Practice Nurse Educator, Clinical Lead, Care Group Lead, Service Manager, Occupational Therapy Manager, Physiotherapy Manager, Lead Clinical Psychologist and Lead Therapist We discussed the ward management, the CQC Inspection Report and their recent changes in response to the issues raised by the CQC and staff recruitment difficulties.

Limitations

The Enter & View Visit was not designed and nor does it claim to provide a representative view of patients' experience at Queen Mary's Hospital, Roehampton, but to give a picture of the care we observed on the day of the visit to the Gwynne Holford Ward through:

- Conducting broad semi-structured conversations with patients
- Collecting a range of patient experiences
- Identifying and reporting where patients have concerns
- Observing areas of practice on the ward
- Identifying from these experiences areas for future consideration if necessary

The Enter & View Visit gathered data from patients on the Gwynne Holford Ward. Individual experiences will inevitably be different, based on their needs and expectations of care at the hospital.

The patients had a wide range of neurological conditions and/or were amputee patients and not all were able to fully participate in interviews. In addition, the patient-led nature of the methodology allowed patients to focus on the issues that were more important to them and not respond to questions that were less important. The patient led methodology in conjunction with the nature of the patients meant that not all themes could be discussed with all patients.

Analysis

The qualitative data analysis of the patient interviews was carried out with an approach based on:

- Summarising the individual volunteer reports from patient interviews by theme
- Analysing the data according to the themes
- Assigning the overall sentiment of comments (positive, neutral, negative, no data)
- Preparing a descriptive summary for the themes
- Reviewing the results
- Summarising the observational reports from the volunteers by themes.

During the analysis, data was considered in terms of frequency, specificity, emotion and extensiveness under each question. Responses were grouped by question.

While every attempt has been made to provide a sense of scale to the issues raised by patients throughout this report, the qualitative nature of the feedback does not allow for these to be robustly quantified. The findings presented identify positive and negative aspects of the patient experience and raise awareness of issues that may need to be considered for further examination.

Sample

There are 36 beds on the ward. A total of 14 patients were interviewed, 1 with the support of a relative and 2 patients declined to be interviewed.

Discussions were held with 3 visitors

Discussions were held with the following 13 staff members: Head of Nursing for Neuro-sciences, Matron, Clinical Nurse Specialist, Care Group Lead, Service Manager, Occupational Therapy Manager, Practice Nurse Educator, Physiotherapy Manager, 2 permanent members of nursing staff, 2 agency nurses, 1 Healthcare Assistant, Pharmacist.

Each volunteer did at least 2 Observational Audits and 13 were done in total and the data from these has been reported under the themes used for the analysis of the patient interview data.

The report has been broadly structured by the questions asked.

Overall Care and Rehabilitation Treatment

Patients were asked twice during the interview about their overall views on their care and rehabilitation, part way through the interview and at the end and both sets of responses were overwhelmingly positive. Care and treatment were described very positively with empowerment and control being given to the patient and staff challenging the patient to do as much as they could. The staff were described as friendly and their interaction with staff as warm and friendly. The patients' comments included:

- "They are all very good at their job and it makes me feel comfortable"
- "Top notch, everyone is so understanding it has been really helpful"
- "First class: NHS at its best"
- "Very professional standard"
- "Well cared for and happy."

One person said it was "satisfactory" and another said "every day I see someone different but the nurses are the same"

Suggestions for Improvement

There were very few suggestions for improvement to the service but those there were included:

- "Sometimes I have asked for something and then it is forgotten and I have to ask again later"
- Catering poor, they need to address nutritional needs of patients"
- "Administration is slow e.g. contacting GP"
- "Sometimes they take my observations late, so I am late back for my gym sessions in the afternoon"

The positive responses of the patients were backed up by two visitors who told us that they were very pleased with the care and treatment their relatives were receiving and praised the responsiveness of the staff. One of the visitors told us that the biggest challenge was getting a referral to the Gwynne Holford Ward.

Provision of Activities on the Ward

The Management Team told us that a variety of activities and support services were provided to help patients regain life skills e.g. functioning bathrooms and kitchens where patients can practise being able to use these facilities independently. There are now two Activity Co-ordinators in post who can also take people out. These were new posts and after Christmas this provision was going to extend to the weekends. Rehabilitation assistants already work at weekends. Patients also have weekends at home to help them and their families get orientated for life back at home.

One patient commented that the weekends were boring and quite a low point. They thought that if the gym was available at the weekends this would help a lot and access to more recreation facilities at the weekend would also be welcome.

We have now been informed that the Activity Co-ordinators are working a shift pattern that covers weekends and some late shifts and the patient feedback from this has been very positive.

There was a mixture of responses on the provision of activities on the ward and this also reflected the differing needs of the patients interviewed, who ranged from ward based and lacking in mobility through to very mobile and active patients. There was also a wide variation in age.

Six patients were aware of the activities they could join in and were very positive about them, some saying they were involved in them most of the day and described them as "brilliant" and, "fun". However five patients were unaware of any activities. Two of these had only recently been admitted to the ward and the other didn't feel there was anything to do, but they did go to the café in the hospital. Four of the patients were not interested in other activities, mainly because they were very involved in their rehabilitation and gym sessions and wanted to rest when they were back on the ward.

We have been informed that the extension of the Activity Co-ordinators hours and also linking with other organisations has provided an opportunity to further promote the activities available. The Multidisciplinary Team approach is also being used to encourage patients to attend activities.

Communication

The majority of patients told us that the overall communication between themselves and the multi-disciplinary teams was very good. The staff were described as friendly but firm and had given positive messages focussing on what the patient could achieve and how to maximise recovery. Comments from patients included:

- "Good, working well"
- "Very professional they really know what they are doing"
- "Brilliant, amazing staff"
- "The staff and all the teams communicated well"
- "They all seem to talk to each other a lot"
- "The nurses are lovely"
- "Communication between all the staff is excellent"

One patient told us that whilst communication on the ward was good, there were questions and misapprehensions that the patient had come into the ward with. They thought some of these could have been addressed prior to surgery, especially in relation to likely levels of ability following amputation.

Communication in relation to sensitive issues and difficult news (such as always needing to rely on a wheelchair to some extent) was reported by patients to be handled well by staff.

We observed that staff routinely wore their name badges and their names were clearly displayed on 10 occasions. One staff member had a badge obscured by a scarf and another had a broken one in their pocket. We saw that nursing and therapy staff routinely sought patients' consent prior to undertaking care and were using preferred and appropriate names in their communication (10 and 11 observations). They were also attentive and responsive when spoken to by patients. The quality of the relationship between staff and patients seemed good. Staff were communicating clearly (observed 13 times) and the patients were seen to understand the staff (seen 12 times).

The only negative comment was from one patient who said that his hearing was poor and sometimes he found it difficult to hear what was being said. In addition we did observe a patient who required propelling in a wheelchair, being left in the corridor whilst staff had to attend to something else, though they were not concerned or complaining.

Patients' bedside information boards were observed to be up to date and there were pictorial prompts to support patients with cognitive impairment.

When patients were asked if they knew who to talk to if they had any concerns, they all said "yes". The staff cited were the ward sister, named nurse, the doctor and the physiotherapist.

The Trust has informed us that provision is made for patients with communication problems. A Speech and Language Therapist and the Multidisciplinary Team approach are used to help support these patients. The assessment feeds into the patient centred care plans and is available to all the team providing the direct care.

Care and Treatment Planning

Do the Clinical Teams Work Well Together Caring for You?

The majority of the patients spoken to (8 out of 10) thought that the clinical teams and therapy staff worked well together. They were described as "all very professional", "all excellent" and "all equally good" amongst other positive comments. Only two patients were not sure about this aspect of their care.

Care Plans

All the patients reported being involved in their care plans and setting goals for their progress to a greater or less extent, depending to some extent on their capacity. They described to us regular monitoring meetings and reviews of progress and goal setting discussions. One patient described his goals and progress and the progress he was making towards getting home. Other patients said that:

- "Yes always (involved in treatment plans), weekly review meeting monitors progress"
- "Very much so and targets are set monthly"
- "I have a care plan that has been made for people with my type of problem and then I have a personal plan with the Physio and the OT"

Most of these patients (8 out of 10) were also aware of what was happening next in their rehabilitation and treatment.

Gaining Independence

All the patients we spoke to (thirteen) said that they thought staff had helped them re-gain independence. One told us that "when I arrived I never thought I could be this good". Patients spoke highly of the nursing staff and described an attitude of compassion and of empowering patients to take control and we observed this through their interactions.

The staff were observed on twelve occasions actively promoting the patients' physical and mental independence.

Where do the Rehabilitation Activities Take Place?

All the patients were aware of where the rehabilitation activities took place and told us about using the main gym, the therapy kitchen and physiotherapy rooms. They described the sorts of programmes they followed and some spoke highly of sessions they undertook and the positive effects they were having.

The layout of the ward on two floors was rather sprawling and we found it difficult to get around and access all the facilities.

Discharge Plans & Discharge Communication

The majority of patients are discharged back to their Clinical Commissioning Group area for the next stages of their care either in other rehabilitation facilities or back in their homes. The discharge procedure starts approximately half-way through their stay and their local health and social care services are involved together with family members. On admission a discharge date +/ – 10 days is set. At Queen Mary's Hospital the Wandsworth Social Workers work with the hospital team, but for patients from other local authorities this can sometimes be more difficult to co-ordinate and can lead to longer stays. Currently they have five patients staying beyond their expected discharge date because of social care delays.

Nine of the patients we spoke to were aware of when they were likely to be going home. Some were able to give us more details than others, but in most of these cases it was obvious that this was something that was been discussed with them. They were also able to tell us about the arrangements that were being made for them to cope when they returned home. Among the feedback patients gave us was that:

- They were going home at weekends and were aware of the plan for returning home. So far that plan was on track. A wet room was being installed and this had been part of

the plan since before their amputation. The patient was not sure what would happen at home in terms of adaptations to enable them to open the front door and was not aware of all the arrangements and adaptations that would be made for returning home.

- They were learning domestic skills e.g. cooking and working in a kitchen
- They had made a number of visits home and had weekend stays
- Their family had been supported, so they are ready for them to go home. They said they felt confident.

The Trust has informed us that the Discharge Co-ordinator continues to work with other members of the Multidisciplinary Team and to link up with the hospital's main team managing complex discharge needs. They are constantly reviewing their patients' needs.

Respect, Privacy, Dignity

All the patients told us that they were treated with respect and dignity and that their privacy was respected. "They are very respectful" one patient told us. Another patient who had restrictions on their freedom of movement explained how they had been able to reach a compromise with the staff on this.

The Healthwatch Richmond Team observed that the cover provided by the bedside curtains was good and their use, when needed, was positively rated 13 times. The curtains were all clean and well kept.

We also observed a number of private areas available for use by staff, patients and their relatives for discussions.

Meeting Individual Needs

All the patients spoken to felt that their individual needs - religious, cultural and dietary - were being met and three patients gave us examples of how this has happened. One said: "they are very good at making sure if you need something different they can get it".

Cleanliness

The patients commented positively on the cleanliness of the ward and the Healthwatch Richmond volunteers observed a well maintained environment that was clean and tidy, patient friendly and patient focussed. The exception was one bay in a poor decorative state. We have been informed that there has now been some decoration undertaken to the bays.

A few patient bedside areas were untidy but this was personal choice. Patients were encouraged to be as independent as possible and manage their own space, which in some cases meant the bedside area was untidy.

The patients looked clean and well cared for and the staff were clean and tidy and we observed them routinely hand cleansing whilst carrying out their duties.

The displays on the ward noticeboards covered useful information but would benefit from being more interesting and easier to read.

Staffing Levels

During our visit the senior nurse managers told us that nurse staffing vacancies had been high but these were now decreasing, down from 60% to 40%, but that it is still a challenge to recruit Band 5 nurses. The agency staff used by the ward are block booked so they work regularly on the ward. They attend training and they have supervision like the permanent staff. We have been informed by the Trust since our visit that recruitment initiatives are ongoing and they now have 2 new Band 5 nurses awaiting start dates. They have also been out to advert for rotation posts which they hope will attract Band 5 nurses who will then be able to rotate around neurosciences and surgery. Once the new recruits are in post their overall vacancy rate will reduce to about 15% (this includes the Rehabilitation Assistants as well).

The consolidation of patients' beds on one floor has helped with staff capacity as has the implementation of integrated therapy teams, including nurses, who are allocated to each bay.

Conversations with three agency staff confirmed they had worked on the ward for many years and that they receive training and supervision.

The ward normally has 5 nurses and 6 Healthcare Assistants per shift and student nurses are supernumerary. In addition when there are patients who are at risk of absconding they are allocated an extra, permanent member of staff for one to one supervision, 24 hours a day. Currently three patients require this.

There is now a new Practice Nurse Educator, who is supernumerary, and we observed that she was clearly visible on the ward and supporting staff. The Matron and the Clinical Nurse Specialist were also clearly visible all the time during our visit and they and the Practice Nurse Educator provided clear leadership.

The majority of patients who discussed staffing levels said there were enough staff on the ward (10 out of 12). Two patients thought that there weren't always enough staff on at weekends and one patient reported that sometimes they thought they were short of nursing staff. The Healthwatch Richmond volunteers observed sufficient staff on the ward and that call bells were responded to promptly, which was also backed up by the patients.

Staff Training

Clinical supervision is mandatory for all clinical staff and a Clinical Psychologist facilitates the supervision sessions for nurses. Matron showed us the supervision rota with session dates arranged bi-monthly and dates booked for the full year. She said that initially some staff had been apprehensive about attending clinical supervision, but they now really valued the protected time to attend.

Matron herself has 1:1 supervision on a weekly basis at St George's Hospital and she also valued the protected time.

Two staff members backed up the information about regular clinical supervision, including an agency nurse, and they said that it is mandatory and they felt it had helped them.

In addition to clinical supervision, there is monthly Multidisciplinary Team Reflection supervision. Here staff are encouraged to bring a case to discuss and all staff are asked to take turns at presenting cases. The Trust has informed us that there has been a great improvement in multidisciplinary team working and there have also been team building days. Feedback from staff via focus groups and staff meetings has been very positive.

Nursing Handover

Whilst we did not observe a nursing handover session, Matron informed us that a therapist and psychologist usually attend nursing handover to ensure a Multidisciplinary Team approach to care. This gives other members of the team the opportunity to hear about the night shift and any actions taken. A Therapy Assistant also assists nursing staff in helping the patients get dressed and washed in the mornings. This was introduced in response to the difficulty in recruiting band 5 nurses and provided an opportunity for shared learning. A member of staff told us it helped as the therapist could give advice on the best way to encourage independence for patients.

Medicines Management

A new initiative of the Pharmacist working on the ward has had a positive impact on medicines management. There had been problems with administering time sensitive medications and medication errors previously and we were told this was now improving. The Pharmacist provides staff training on the ward about the medications, medicines management and related considerations and also helps to support patients with taking ownership of their self-management of medication.

Reporting of incidents had increased but the significance of the incidents had decreased, which the Pharmacist considered indicated that learning from incidents is being applied and that subsequently there has been a reduction in harm from medicine incidents. There is a national risk management grid used by hospitals to grade incidents, which is being used. The presence of the Pharmacist was also improving the speed at which controlled substances were dispensed as she was able to provide a second signature so staff no longer needed to leave the ward to get this. Similarly the presence of a pharmacist on the ward had increased the management of medications in terms of correct amounts and types of medications available for dispensing and audits of patient medications.

The Pharmacist told us she enjoyed her role and found being ward based very rewarding. It also provided a valuable addition to a large ward with a diverse range of patients, medicine needs and medicine management processes (e.g. locked personal medication cabinets, which we observed above all the patients' beds).

Patient Medication Awareness

Interviews with patients and our own observations showed a high level of understanding by the patients of the medication they were taking. Most patients said they received the

correct medication, the correct dose and at the correct time and they confirmed that they were encouraged to manage their own medication as much as possible. We observed a graded handover of control of medication to a patient.

Pain Management

Ten of the patients discussed pain management with the Healthwatch Richmond volunteers. All who required it reported that this was being carried out well. They told us that they were regularly asked about pain levels, including those patients who had had no pain to date. The Matron and the Clinical Nurse Specialist informed us that there are two pain link nurses, who attend meetings at St. George's Hospital and feedback to staff on the ward.

Duty of Candour and Incident Reporting

The ward has undertaken a range of initiatives to improve patient safety and increase incident reporting. The Matron and the Clinical Nurse Specialist explained the systems in place to improve incident reporting and empower staff to raise any concerns they had. The systems included:

- A notice board directly opposite the reception desk clearly displaying the principles of the 'Duty of Candour' and clear information about raising concerns. This was applicable and visible for both staff and patients.
- A '*You said/we did'* document on the noticeboard which referred to suggestions and concerns raised by patients. This documented what actions had been taken.
- A suggestion Box on the front desk that patients could use anytime to submit suggestions and concerns.
- Regular patient involvement meetings with the Matron
- Weekly one to one meetings between Matron and the individual patients.

Staff and patients told us that they felt able and confident to raise concerns and all said they did. One permanent staff member said she felt very confident in raising any concerns and reporting incidents. She said it had "…been a difficult time with managers on long term sick leave, but now it is better". She felt there was an open door policy now and said "Suggestions are taken on board".

An agency nurse who had been on the ward a long time said that it was now easy to report incidents, as there was a generic password on one computer to enable easy reporting of events as they happen. When asked if she felt confident to report incidents or worries she answered, "Yes, definitely".

It is encouraging that the number of incidents being reported has increased recently. This is a sign that staff are not afraid to report incidents or near misses.

Falls Management

The Falls Protocol and the number of falls that had occurred were clearly displayed on a noticeboard in the main corridor. The Clinical Nurse Specialist explained the process and

told us that the tool has been designed to address the number of falls and ensure a 'rapid response team' sees patients quickly following a fall. She is very keen that a culture of learning is the norm. We were told that the fall must be recorded immediately and copied to key members of staff, including a Consultant. Following a fall the patient is urgently assessed and the steps needed to be taken by staff including how to appropriately record the details are clearly explained.

There is also a 'Falls Champion' on each ward and we were told that the number of falls has reduced since the protocol has been implemented. Staff were aware that falls were the most frequent incident that occurred on the ward.

Two patient told us about the falls they had had which related to wheeled furniture use, wheelchair use and transfer from bed to chair. These may have been avoidable with closer supervision and advice on using wheeled furniture.

We followed up these reports with the Trust and the Matron informed us that patient safety in transfers and using equipment is assessed by the physiotherapist and the occupational therapist on the day of admission and re-assessed within 72 hours after a fall. Their 72 hour response protocol takes into consideration multiple other factors, including medications, postural hypotension, sleep, pain, incontinence which are all reviewed based on the context in which the fall occurred. In order to prevent falls in patients with cognitive difficulties (like reduced memory, impulsiveness), they have trialled sensory mats and talking devices, which alert the patient and the staff when the patients attempt to get out from the wheelchair, toilet or bed unattended. We have been informed that these devices have now been ordered.

Deprivation of Liberty Safeguarding (DoLS)

Matron informed us that three patients currently require One to One supervision due to the risk of them absconding. Nurses or HCAs providing the supervision are always supernumerary for the shift they are working.

One patient interviewed had bed rails up and we asked him if he had been told why they were in use and if he agreed with the decision. He told us he had been informed of the reason and was happy they were being used as it stopped him worrying about falling out of bed.

Although no patient identifiable information was shared with us, the Matron explained the patient notes and how they are clearly marked for staff, especially agency staff, to navigate. Any safeguarding or DoLS issues are clearly set out at the front of the notes, so there is no confusion. The notes were securely put away in a locked trolley.

Two members of staff discussed DoLS with us and were knowledgeable on its use and told us that the least restrictive practices were used and a positive approach was taken to risk taking.

Food & Mealtimes

The patients' views on the food was mixed. Six patients described it as good, two as ok and the rest as poor or could be better and a few commented that there was not enough food to meet their needs. We were told that the dieticians work with the patients on their diets, but they have very differing needs. Amputee patients were often asking for a higher calorie intake than they necessarily would require and this needs to be balanced with the patient making healthier food choices. We have since been informed that the dieticians are continuing to work with the amputee patients and adjust their diet to their differing needs.

Patients told us that appropriate food was made available to meet patients' differing cultural needs. Some patients also go to the hospital cafés for drinks and food.

Mealtimes were protected and patients encouraged to join others over meals and dining tables were attractively set up to promote this.

Outcomes

The aim of the Enter & View Visit was to capture the views of the patients and their relatives on the care they had received on the Gwynne Holford Ward and to observe the care and communication taking place on the ward and the quality of the physical environment.

The overall view of Healthwatch Richmond was that the care they observed on the ward was of a high standard. The ward was clean and well-kept and the patients looked well cared for. There appeared to be enough staff on the ward to respond to the patients' needs and the patients' overall view of the staff and the care they were receiving was very positive.

Recommendations

We would welcome further information and an update on the following issues in 6 months from the publication of this report:

1. **Recruitment**
   The success of the new initiatives to recruit staff and its effect on the vacancy rate, particularly for Band 5 nurses.
2. **Falls**
   The impact of the new actions being taken to minimise the danger of falls from the use of wheeled furniture and from transfers from wheelchair to bed.
3. **Promoting activities**
   The impact of the initiatives to promote the uptake of activities provided on the ward.
4. **Food and nutritional needs**
   Have the dieticians' interventions with amputee patients led to improvements in the balance of their diets? Has there been any increase in patient satisfaction with the catering in general?

5. **Teamwork**
   The impact of the initiatives to improve teamwork and Multidisciplinary Team working.
6. **Discharge**
   Have there been any further improvements in discharge procedures and reductions in the number of patients remaining on the ward beyond their expected discharge date?
7. **Administration**
   Have there been any improvements in the support received from Clinical Commissioning Groups or local authorities for patients with complex social discharge needs.
8. **Ward Layout**
   We have been informed that there are no current plans to make changes to the ward layout. Is this likely to change in the future?

Acknowledgements

We would like to thank the staff at Queen Mary's Hospital, Roehampton, for their cooperation and assistance with our visit and the positive way in which they engaged with us and made us feel welcome. We would also like to thank the volunteers who have supported this project and undertaken the Enter & View Visit.

Appendices

Appendix 1: Background Information on the Gwynne Holford Ward

St George's University Hospitals NHS Foundation Trust neurorehabilitation services provide specialist care not available at other hospitals or in the community. The service treats patients from across southwest London and the Home Counties at St George's Hospital, Tooting and Queen Mary's Hospital, Roehampton.

The trust provides specialist neurorehabilitation to patients who require intensive therapy following acquired neurological conditions resulting in physical or psychological disabilities. This includes patients who have had strokes, traumatic injuries to the brain or spine, anoxic brain damage, diseases or infections of the nervous system, and long-term conditions like multiple sclerosis. Services are provided on an inpatient or day patient basis. They also provide a range of assessment and diagnostic clinics and advise on the care of patients at other treatment centres.

The comprehensive treatment service is provided by multi-disciplinary teams to address patients' needs and maximise their recovery. The teams include nurses, occupational therapists, physiotherapists, social workers, speech and language therapists, medical staff and clinical neuropsychologists. The service also has consultants in neurology, stroke medicine, rehabilitation medicine, neuropsychiatry and clinical neuropsychology, as well as doctors in training. Visiting clinicians include dieticians and pharmacists.

The Gwynne Holford Ward is part of the Wolfson Neurorehabilitation inpatient service based at Queen Mary's Hospital, Roehampton.

Wolfson Neurorehabilitation Centre

This is the inpatient service based at Queen Mary's Hospital for neurorehabilitation. The team includes speech and language therapists, occupational therapists, physiotherapists, doctors, nurses, clinical neuropsychology, a dietitian and social workers. Other professionals e.g. psychiatry or pharmacy may be asked to join the treating team should their input be necessary.

Patients are looked after by a team of nurses, therapists and doctors who are highly experienced in caring for patients needing rehabilitation. Inpatients are admitted for an approximate 12 weeks programme and follow individually tailored programmes based on goals set by the patient and their family or carers, in collaboration with the treating team. Close liaison is maintained with families, carers and community services, including statutory and voluntary organisations, to help patients' progression from the inpatient setting to the home environment.

Day patient and outpatient services include individual and group cognitive rehabilitation and vocational rehabilitation to get people back to work. Support groups for patients and families are also available.

The Vocational Rehabilitation Programme helps neurological patient back into employment, through a tailored approach. The team provide assessment, guidance and support, helping clients regain their confidence. To access the brochure outlining the service click here Wolfson Brochure

Frequently asked questions F-A-Q Questions

Location

Therapy – Wolfson Neurorehabilitation Centre (ground floor and lower ground floor, Queen Mary's Hospital)
Beds 36 – Gwynne Holford Ward, lower ground floor, Queen Mary's Hospital

Contact number

Wolfson Neurorehabilitation Centre: 020 8487 6125 / Gwynne Holford Ward: 020 8487 6126

Appendix 2: St George's University Hospitals NHS Foundation Trust - Care Quality Commission Inspection June 2016

Community Health Inpatient Services – Queen Mary's Hospital

This service comprises of the Mary Seacole and Gwynne Holford Wards.

OVERALL RATING FOR THE SERVICE	*INADEQUATE*
Are the Services Safe?	REQUIRES IMPROVEMENT
Are the Services Effective?	GOOD
Are the Services Responsive?	REQUIRES IMPROVEMENT
Are the Services Well-led?	INADEQUATE

Overall Summary

The Care Quality Commission rated this service as inadequate because:

- Changes had been made to Gwynne Holford Ward since our last inspection without due regard for the impact on people's safety. The premises were not appropriate for the service provided and the layout had contributed to fragmented care. The care was not delivered in a way that focused on people's holistic needs.
- There were critical shortages of staff on Gwynne Holford Ward and not all of the staff on the ward had the right skills and knowledge to do their job. Staff told us that patients were being admitted with more complex needs and they found this challenging.
- Bedrails were used for many patients, without it being discussed and there being any clear indication for their use. There had been no consideration by staff that the use of bedrails was a form of restraint and was possibly depriving patients of their liberty.
- There was a lack of urgency by nursing staff to get the deteriorating patient medically assessed.
- Although they saw some good areas of practice, there was variable implementation of evidence-based care. Processes in documentation, administration of medicines, infection control and prevention and responding to the deteriorating patient were weak areas on Gwynne Holford Ward.
- Incidents were not consistently reported or acted upon on Gwynne Holford Ward and opportunities to learn from these and improve care were missed.

However:

- Staff felt valued by their peers, matrons and ward managers. Staff had a strong focus on providing compassionate care.

- There was excellent multidisciplinary team working and there were clear referral processes. Both wards aimed in their rehabilitation programmes to maximise the functional and physical ability of the patient.

See the report: St George's Hospital Community Inpatient Services, CQC Report June 2016

Appendix 3: Interview Audit

Queen Mary's Hospital, Roehampton, Gwynne Holford Ward - Interview Audit

Inpatient Neuro-rehabilitation Service
PATIENT INTERVIEWS WARD BASED ENTER & VIEW VISIT

Volunteer's Name …… Date & Time …14/12/2016
Patient No ……

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 ☐

Are there activities for you to do on the Ward? (As well as rehabilitation activities.)
Where do the rehabilitation activities take place? On the ward? Brysson Whyte Department?
How would you describe the overall communication between yourself and the clinical teams e.g. doctors, nurses, physiotherapists, occupational therapists, other staff group (please specify). Include both positive and negative experiences
Have you been involved in your care plans and setting your goals for your progress? Do you know what is happening next?
Do you know when you are going home? What arrangements are being made for you to cope when you get home?
Do you feel you are treated with respect and dignity? Do you feel that your privacy is respected?
How would you describe your care and rehabilitation treatment? Is there anything that you think needs improving?

Do you feel that the clinical teams e.g. doctors, nurses, physiotherapy, occupational therapists, other staff group (please specify), work well together in caring for you? (Any group in particular?)
Do you think that staff are helping you /have helped you re-gain independence?
Do you feel your views are respected?
Do you know who to talk to if you have any concerns?
Do you feel your individual needs are met? Religious, cultural, dietary needs, etc.? If 'No' what else could be done?
How would you describe the overall tidiness and cleanliness of the ward?
Do you feel that there enough staff on the ward at all times?
What medication are you taking?
Do you always receive the correct medication The correct dose At the time you should receive it.
How do you feel your pain is managed?
How would you describe the food?

How would you describe your overall care and rehabilitation treatment on the ward?

OTHER COMMENTS - Do you have any additional comments about your care? These comments are very helpful to us as we work to improve the quality of care provided to patients.

Appendix 4: Observational Audit

Queen Mary's Hospital, Roehampton, Gwynne Holford Ward - Observational Audit

Inpatient Neuro-rehabilitation Service
WARD BASED ENTER & VIEW VISIT
Volunteer's Name ……. Date & Time Completed……..14/12/2016
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**
Are staff wearing name badges		If 'No' specific staff group.
Are name badges clearly displayed?		If 'No' specific staff group.
Are nursing & therapy staff seeking consent from the patients prior to undertaking care?		**If 'No' specific staff group.**
Does there seem to be a good quality to the relationship between the patients and the care staff?		
Are staff using patients' preferred and appropriate names in routine communication?		
Is any ward information available for those with language difficulties or disabilities?		
Are staff clearly communicating with the patients?		
Do the patients understand the staff?		
Were the patient bedside information boards updated?		
Assisting the Patient & Staffing		
Do there appear to be enough staff on the ward?		
Did you observe staff actively promoting patients' independence (mental and physical)?		
Is the patient's self-care equipment & mobility aids within easy reach i.e. locker, table, jug and glass, call-bell?		
Is effort being made to make mealtimes a social event?		
Is the call bell responded to within 5 minutes?		
Are patients being encouraged to be as independently active as they can?		

Are the nursing team assisting patients when required with meals, i.e. help to sit up, help with cutting food, help with eating, offering patients more food?		
Did you observe any ad-hoc nursing rounds to check if patients are comfortable and able to do things for themselves? (intentional rounding / comfort rounds)		
Is manual handling being carried out appropriately?		
Are patients given the opportunity to wash hands/use hand wipes before meals?		
Are nurses and other staff attentive and responsive when spoken to by the patient?		
Did the nurses inform (by verbal and tactile communication) unconscious or severely ill patient of nursing interventions?	Would this be applicable in this setting?	
Medicines Management		
Do patients know what medicines they are taking, are they getting them on time, right ones?		On interview form and difficult to observe unless an error is noted
Privacy and Dignity		
Do all curtains and screens provide adequate cover and are they used when needed?		
Is there a private area for discussion with patients and their relatives? (Ask staff)		
If YES, state where--		
Cleanliness		
Is the patient bedside table/area clean and tidy?		
Is the ward clean and tidy?		
Are patients clean?		
Are staff hand cleansing?		
Do staff look clean and tidy?		

OTHER COMMENTS- include any good and poor practices observed