East London NHS Foundation Trust

<Provider ID>

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWKX7	East Ham Care Centre, Shrewsbury Road, London		E7 8QP

This report describes our judgement of the quality of care provided within this core service by East London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by East London NHS Foundation Trust and these are brought together to inform our overall judgement of East London NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall we rated this service as **good** because:

- Staff promoted the privacy and dignity of patients. We also observed staff to be caring in their interactions with patients. All the patients we spoke with told us that staff were kind and treated them with respect. We did not come across any examples where this was not the case. Patients and relatives felt involved and included.
- Services were safe. There was a good culture for the timely reporting of incidents including all serious incidents and the trust were able to identify themes and trends across community inpatient services. Safeguarding processes enabled the identification of possible abuse and encouraged reporting. Processes for the safe administration of medication were in place. Patient records were up to date, written legibly, dated and signed. Wards were clean and staff were trained in infection prevention and control. The wards were fully staffed and there were enough staff to meet the needs of the patients. .
- The wards delivered care in line with current national guidelines. Patients received timely pain relief. Staff understood the importance of nutrition and hydration. Patients received adequate assistance to eat and drink. Staff were also able to access key skills training appropriate to their role.
- Patient admissions and discharges were appropriately planned and managed to ensure effective care and transition with the acute hospital and community services. Staff understood their roles in regards to patient consent and capacity. There was good multi-disciplinary working and inter-agency working.
- The wards were meeting the needs of vulnerable people. For example, a range of 'easy read' and braille information was available to patients. Community therapy assessments had taken place and the multidisciplinary team was involved in preparations for discharge. Patients reported that their care and treatment needs were being met. It was reported that call bells were responded to appropriately and night staff were also responsive.
- Staff reported to us that they had confidence in their leadership, who they found responsive, and that members of the executive team were visible. There was a governance structure that enabled managers and senior managers to appropriately monitor and review the quality of service provision.

However:

The treatment rooms where medication was stored were too hot. Trust managers were aware of this and taking steps to ensure the rooms were an appropriate temperature.

Summary of findings

Background to the service

East London NHS Foundation Trust's community inpatient services for adults are provided in the Cauzabon Unit and Fothergill Ward at the East Ham Care Centre.

The Cauzabon unit is a rehabilitation unit with 23 beds, all of which are single en-suite rooms. The unit accommodated patients over the age of 50. The majority of the beds were provided for patients who need slower stream rehabilitation after a period of time in an acute hospital. The unit also provided two virtual ward beds, providing care for people with complex medical and social care needs. The average length of stay on the Cauzabon unit was six week. During this time, people were provided with rehabilitation and had care packages organised to enable them to return home. Longer stays were possible for people with social care needs who needed longer periods of rehabilitation.

Fothergill ward provided NHS continuing healthcare to Newham residents over the age of 50 to meet their continuing physical or mental health care needs. Fothergill Ward also provided respite care to patients with similar needs. Referrals were made through a multidisciplinary team via the NHS continuing care panel. The unit did not have a target average length of stay due to its continuing care focus and the need to provide patients with on-going care.

Patients on both wards were admitted from home and from local acute hospitals. Referrals for admission came from neighbouring acute hospitals, GPs and community health services. Rehabilitation and continuing care were provided to people, including for those living with dementia with rehabilitation potential.

Both wards were previously inspected by the CQC in July 2013.

Our inspection team

The team that inspected this core service consisted of a CQC inspector, physiotherapy manager and a modern matron.

Why we carried out this inspection

This inspection was part of the comprehensive inspection of East London NHS Foundation Trust.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?'

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an unannounced visit on 8-9 June 2016.

During the visit we spoke with over 20 staff on the wards. These included a clinical leads; one modern matron; two ward managers; one GP; two nurses; one occupational therapists; one physiotherapists; one pharmacists; five health care assistants.

Summary of findings

We talked with eight people who use services. We observed how people were being cared for and talked with four carers and/or family members and reviewed care or treatment records of people

East London NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as **good** because:

- Incidents were reported quickly. The service was able to identify themes and trends from incidents. When needed, staff were learning from incidents and improvements were taking place.
- Safeguarding processes enabled staff to identify potential abuse and encouraged reporting.
- Processes for the administration of medication meant that patients received their medication in a timely manner, and were involved and consulted in the need for pain relief.
- The overall standard of documentation was good. Staff completed assessments for each patient. These included assessment of skin integrity, nutrition, pain and mobility and risk of falls. Overall records we reviewed were up to date, written legibly, dated and signed.
- Wards were clean and staff were trained in infection prevention and control.
- Premises were well maintained and equipment was serviced in accordance with manufacturers instructions and servicing schedules. However, equipment storage space was limited.
- Community inpatient services were fully staffed.
- There was a business continuity plan in place to manage disruptions to services and major incidents.

Detailed Findings

Safety performance

- The community inpatient service no longer participated in the national safety thermometer programme; this is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Instead the trust had introduced a quality improvement (QI) programme to measuring 'harm free' care and safety information data and make improvements. The QI programme monitored safety indicators including pressure ulcers, falls and urinary tract infections (UTI). Staff told us QI was how the service audited and assessed the services performance.

Good

Are services safe?

- Both the Cauzabon unit and Fothergill ward used the safety cross to monitor commode incidents and patient falls. The safety cross information was clearly displayed on the walls of both units. The Fothergill ward had no new incidents in June 2016. The Cauzabon unit had three incidents relating to one patient. We saw that the unit had used the safety cross information to identify a pattern in the patients risk of falls. The unit had taken action to address the risk and were providing one to one care for the patient at night.

Incident reporting, learning and improvement

- Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). There had been no STEIS incidents reported by this service between May 2015 and April 2016.
- Incidents were reported using the online electronic reporting system and this identified trends and provided opportunities for learning from incidents.
- The trust had arrangements to review all the incidents, grade them and agree how they should be investigated. There was a target for all serious incidents (SIs) to be reported within 24 hours and incident reports were signed off on a weekly basis. Staff had received training on incident reporting and were encouraged to report.
- The incident themes were shared with managers through their monthly 'improvement, safety, and quality' group. Incidents were standing agenda items in team meetings and staff received automatic email alerts about incident learning. Inherited pressure ulcers were reported through the electronic incident reporting systems and referring acute partners were alerted when this occurred. Pressure ulcers of a grade three or above were reported as a safeguarding alert. Safety alerts were available to staff in team folders on the trust's intranet. Service leads had to respond to the quality committee outlining any actions they had taken in response to the alerts.
- Senior staff told us there hadn't been any serious incidents on Fothergill Ward for two years. On the Cauzabon unit, the electronic incident reporting system showed that in the last two months they had recorded three serious incidents which were still undergoing investigation at the time of our inspection. Two of the serious incidents included patients' personal property going missing. The trust had responded promptly to the incidents and prior to the investigations being completed. An action plan was in place including installing cameras in the manager's office and introducing lockable lockers opposite the nursing station for patients use. The ward manager had also reported the incidents to the police.
- The electronic incident reporting system prompted staff to record whether duty of candour requirements had been fulfilled. Staff understood the need to be open and supportive with the patient and their family following an incident.

Safeguarding

- The trust had a safeguarding team whom staff could contact with any queries for children and adults. The team also supported with wards with complex cases.
- There was online safeguarding training and training was also carried out by the safeguarding team on an ad hoc and 'as required' basis. Agency staff received the same safeguarding training as permanent staff. All community inpatient staff had received training in both children's and adult safeguarding level one as part of their mandatory training. Staff received further training at a level appropriate to their area of work.
- Safeguarding information was available to staff on the trust intranet. The staff information board contained included information on the contact details of the trust safeguarding team including out of hours contact. This included guidance for staff on contacting the local authority safeguarding team. Staff we spoke with were aware of the trust adult safeguarding leads and knew how to contact them. The leads were described by staff as being helpful and supportive with safeguarding issues. Staff also told us that social workers worked in the East Ham Care Centre and could be approached to advise on safeguarding issues.
- Staff we spoke with were able to describe the categories of abuse and how they would report potential safeguarding issues. Issues were reported to the safeguarding lead for further investigation. Learning from safeguarding investigations was shared at team meetings and across the service where appropriate.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.

Good

Are services safe?

Medicines

- We reviewed the medicine management arrangements on both wards.
- Access to the treatment rooms were secured with a key pad and cupboards within the room were locked. However, we found that the room temperature was regularly recorded as above the temperature recommended for the storage of medication. This was identified on the community inpatients risk register. The trust had purchased air conditioning units to regulate the temperature; but the units could not be used due to needing to be ventilated and the rooms not having windows. Staff told us the trust were aware and were again reviewing the situation to remedy this.
- The pharmacy team at the trust carried out monthly and quarterly audits to make sure that medicines were managed safely on the ward. We viewed the medications audit for 5 May 2016, there were no actions arising from the last audit.
- Members of the pharmacy team at the trust visited the wards every weekday. They spoke with patients when they arrived on the ward to take a detailed medication history and check that the list of medicines prescribed was complete and correct. They would include family members in the discussion if they were involved in helping their relative manage their medicines. Members of the pharmacy team at the trust were involved in planning for discharge. The trust provided information sheets for people to explain their medicines, as well as medicine record sheets for use by patients, relatives or care workers. There was a process in place to support patients to take their own medicines to help maintain their independence and get them ready to manage at home.
- We observed a medicines round on the Cauzabon unit. The staff nurse wore a 'do not disturb, medicines in progress' red tabard. The Cauzabon unit, were monitoring the effectiveness of the use of tabards which had been introduced as a QI programme initiative. The outcome was that the tabard had not made a significant difference. However, the initiative identified that incoming telephone calls could be disruptive. An action plan was in place that incoming calls to community inpatient services during medicine rounds would be dealt with by unqualified staff or administrators. If the call required a nurse to speak with the caller, then their details would be recorded and the nurse would contact them following the drugs round.
- Information in the treatment room included contact details of how to order discharge medication including controlled drugs (CDs). Also how to order stock medicine from a pharmacy company and trust guidance on national patient safety alerts (NPSA).

Environment and equipment

- We saw services were provided in well maintained premises. There was full disabled access with lifts, ramps and disabled toilet facilities all present. There were appropriate facilities. For example the Cauzabon unit which supported people with their rehabilitation had a kitchen where patients could work with therapists to develop their independent living skills.
- Entrances to all ward areas were secure, entry was granted by a member of staff via an intercom for visitors during the day and at night.
- Equipment records were identifiable and showed that equipment had been maintained in line with manufacturers' recommendations. For example, the slings and hoists had been serviced in May 2016. Some equipment did not have a sticker attached to the equipment to identify to staff that the service was safe to use. The Cauzabon Ward manager explained that the equipment was new and would have a sticker applied following servicing.
- The Cauzabon Unit and Fothergill ward resuscitation trollies that were checked daily and were up to date.
- We found 'sharps' waste was disposed of in appropriate receptacles which were properly labelled.
- Patient led assessments of the environment showed that in 2015 the East Ham Care Centre scored 99.49% for cleanliness and 96.48% for condition, appearance and maintenance.
- Patient call alarms were available. On Fothergill ward day room did not have a call alarm that could be placed with a patient. The ward manager had moved a desk into the room for staff to work at so that patients using the room would have a staff member available at all

times; but to also allow staff to complete administrative work and make use of the time whilst patients used the room. Patients said that staff responded quickly when they used the call alarm.

Quality of records

- The overall standard of documentation was good. Overall records we reviewed were up to date, written legibly, dated and signed.
- Risk assessments were fully completed for each patient, these included skin integrity, nutrition, pain assessments and falls risks.
- Therapy notes were clear, legible, dated and signed. Physiotherapy notes and care plans were completed at the patients' bedside contemporaneously, signed and dated with consent documented.
- Records were audited, by clinical nurse specialists (CNS) and reported to the lead nurse. We viewed the Cauzabon unit 'case note audit' dated May 2016; this had an action plan that had been implemented where improvements were recorded.
- Patients paper based records were kept in folders on the wall outside patients rooms. However, this did not ensure the privacy of patients' records.
- Staff told us GPs used a different patient record system when visiting patients on the ward. This caused problems for staff in accessing people's information in a timely way.

Cleanliness, infection control and hygiene

- Both wards maintained good standards of cleanliness and infection control.
- The infection prevention and control (IPC) team visited both wards regularly. Staff told us the IPC team were responsive to any queries the wards had. Infection control was regularly audited by the IPC team and the ward staff. Environmental and hand hygiene audits were done monthly. We viewed the Cauzabon Units 'hygiene code monitoring audit' dated 6 May 2016 and saw that an action plan to address improvements had been implemented.
- The Cauzabon Unit and Fothergill Ward were clean and tidy. 'Bare below the elbow' policies were adhered to. Both wards provided modern purpose built environments. Clinical and domestic waste was separated and waste bins were covered and operated by foot pedal. Wards had adequate supplies of personal protective equipment (PPE). We saw staff using PPE appropriately.
- Information from the national patient safety agency on hand hygiene was available on both wards. There was an 'information for staff' noticeboard on both wards that included information and guidance for staff on using PPE. Hand cleaning techniques were on display in both visual and written form. There was information on 'sharps and contamination injuries, accidental exposure to blood borne viruses' guidance, as well as guidance for staff on action to take following an accident and reporting procedures such as contacting infection control link and services. The names and contact details of the IPC team were also available on the board. There were hand gels and notices regarding hand hygiene with technique displayed at the entrance to the both wards. We saw the community inpatients modern matron challenging visitors to the hospital and asking them to clean their hands due to the risk of infection.
- IPC training data from 31 January 2016 demonstrated that 100% of staff were up to date with mandatory IPC training.
- We saw cleaning schedules that clearly set out how and when premises and equipment should be cleaned. Patients we spoke with did not raise any concerns in regards to the cleanliness of either the Cauzabon Unit or Fothergill Ward.
- There had been no ward acquired cases of methicillin-resistant staphylococcus aureus (MRSA) or **clostridium difficile (C.diff) in the previous 12 months. Staff told us all patients were screened on admission for both MRSA and C.diff. Staff at the Cauzabon unit told us all patients who presented infection control risks would be isolated to reduce the risk of cross infection.**

Mandatory training

- The training compliance for community inpatient services at 31 January 2016 was 80.79%. This was below the trust total of 83.10%. The Cauzabon unit had the lowest compliance score for training at 78%.
- The central training department kept training records and sites also kept their own records of mandatory

training. We viewed mandatory training figures during our inspection and these showed overall attendance rates were above the trust targets. For example, both wards had achieved 100% for moving and handling, conflict resolution, and food hygiene.

- Community inpatient services had achieved 68% for the number of staff who had been trained in basic life support. Venous thromboembolism (VTE) at 40% and fire safety awareness at 50% had the lowest compliance score overall for the service at the 31 January 2016. However, we found this was due to staff waiting for training dates. Dates for training updates were advertised and staff were booked to attend. Staff used an electronic learning tool that contained a flagging system for when training was due. Staff confirmed they received reminders when training was due. Staff we spoke with told us they were supported to attend mandatory training by their managers. The ward manager of the Cauzabon Unit told us they monitored staff training. The ward manager showed us the units mandatory training spreadsheet, this recorded that most staff training was up to date in June 2016.

Assessing and responding to patient risk

- The trust had a policy for managing deteriorating patients using the national early warning scores system. This included comprehensive guidance for staff on the trust's resuscitation procedures and staff roles and responsibilities. Patients who were deteriorating and required acute care would be transferred to an acute hospital by staff calling 999 and transferring the patient via ambulance. Staff at Fothergill Ward told us it was rare for a patient to be transferred as most patients were receiving end of life care on the ward and if patients deteriorated the multidisciplinary team would look at the most appropriate means of providing care for the patient.
- On admission patients had a comprehensive assessments including the SSKIN bundle and Waterlow assessment (to assess the risk of the patient developing a pressure ulcer) within six hours. Other assessments including continence and nutrition were also in place. Where needed a care plan and risk assessment had been developed. A visiting family member of Fothergill Ward told us their family member had a grade 4 pressure sore on admission which had healed on the unit. The family member said the staff were very aware of the patient's skin fragility. Staff also assessed patient's level of pain. Patients were asked if they were experiencing any pain regularly.
- MRSA screening was completed within 24 hours of admission. Patients would be seen by a doctor within one working day of admission. A pharmacist would also review new patients for drug reconciliation within a day of admission. Therapists would see new patients daily.

Staffing levels and caseload

- Ward managers told us staffing was not an area of concern for community inpatient services. The lead nurse and ward managers assessed the level of staffing required and allocated staff resources to meet the needs of wards.
- The percentage of staff leaving and vacancies for community inpatient services was below the trust average. For example, in June 2016 Fothergill ward had 100% of posts filled.
- Between 1 January 2015 and 31 December 2015 community inpatient services had 56.5 substantive staff, with 4.6 staff leaving during this period. The service had a vacancy rate during the period of 5.5%. The staff sickness rate for the service 7.6%; this was higher than the trust average of 3.7%.
- Medical cover was provided by a registrar from Newham General Hospital on Mondays, Tuesdays, Thursdays and Fridays. At other times including out of hours a named doctor was on call to advise staff.
- East Ham Care Centre employed 4 activities co-ordinators, who provided group and one to one activities.
- Community inpatient services used an electronic staff rota system. This could report on staff sickness rates, turnover rates and other HR data. It enabled the wards to calculate the number of staff required to meet the needs of patients.

Managing anticipated risks

- Senior managers told us that escalation of risk was normally done from a ward level. Ward managers

Good

Are services safe?

discussed risk with their line managers who escalated to the service director, then onto the risk register if required. The deputy directors meeting reviewed the risk register.

- We viewed the Cauzabon unit risk register. This contained three items including: the temperature in the clinical room sometimes going above the recommended temperature for medicines. The risk to patient valuables was also identified as a risk and an action plan was in place to address the risk.
- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather via the trust's business continuity plan. They said they were able to step-up and step-down beds in response to demand.
- The business continuity plan included major incident planning for the service. Staff told us the trust had conducted a table top exercise for a major incident in 2014. There were further table top exercises planned for July 2016 and September 2016.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as **good** because:

- The service used current best practice guidelines to support patients care and treatment. Staff had access to trust policies and procedures on the trust intranet.
- Patient's had comprehensive assessments that followed national guidelines.
- Patients received appropriate pain relief. Patients were routinely checked to ensure they were comfortable and their pain was adequately managed.
- Staff understood the importance of nutrition and hydration. Patients received adequate assistance to eat and drink.
- There were appropriate arrangements in place for supervision and appraisal of staff. Staff were also supported with revalidating their registrations with professional bodies.
- We found good examples of integrated and multidisciplinary working. Patient discharge was appropriately planned and managed to ensure effective care and transition with community services.
- Staff understood their roles in regards to consent and capacity. The Mental Capacity Act was applied appropriately. The ward staff were supported by a Mental Capacity Act champion who staff could liaise with for advice.

Detailed findings

Evidence based care and treatment

- The service used national institute of health and care excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. Ward managers said they were updated when there were new guidelines that involved changes to practice which might affect their area of work. Changes to NICE guidance was discussed at team meetings. Staff we spoke with understood how NICE guidance informed their care, for example caring for patients with dementia or guidance on pressure relief.
- We saw copies of relevant documents were available at nursing stations for staff to reference, and staff told us they could also access this via the trust's intranet. For example, the Nursing and Midwifery Council code of professional practice.

Pain relief

- Patients received pain relief as prescribed. Patients were routinely checked to ensure they were comfortable and their pain was adequately managed. Pain management was discussed in handover in relation to patients' care and wellbeing.
- The activities co-ordinator told us the sensory room was sometimes used to alleviate patients' pain or anxiety and to promote recovery.
- The June 2015 to April 2016 found that patients experiencing pain or discomfort reported a 10% improvement between admission and discharge when asked to complete a survey of their own experience.

Nutrition and hydration

- Cauzabon Unit staff told us they prioritized and promoted good nutrition. The unit had designed its own nutritional assessment tool.
- The ward manager on Fothergill ward told us all patients needed assistance with feeding.. It was clear that staff understood the importance of hydration. Staff were observed helping patients to eat and drink where needed.
- We observed the evening meal at the Cauzabon unit. Staff checked meals to ensure patients received the meal they had ordered. We asked three patients about their meal and all were positive.
- On Fothergill ward the patient recorded experience measures found that 80% of patients reported the food as "very good" between February and April 2016.
- Where a need for additional support with nutrition and hydration was identified, for example with diabetic

patients, community and specialist nursing staff referred patients to a dietitian, who provided practical advice for patients about healthy food choices and to work with patients to change their eating habits.

Patient outcomes

- The trust participated in the National Intermediate Care Audit (NICA) 2014.
- The lead nurse told us that outcome tools such as the patient reported experience measures were used. The results linked to key performance indicators and were part of the trust's dashboard system.
- The lead nurse held a monthly 'improvement, safety and quality improvement' meeting with ward managers. This reviewed the feedback from these patient outcome measures. The results were also shared at team meetings.
- The wards were using some outcome measures. For example the occupational therapists and physiotherapists told us how they used the mobility scale and goal achievement tools to measure patient outcomes. Also patients were asked to record their own experiences of their care and this showed where they had made progress.

Competent staff

- A corporate induction was completed by all staff joining the service. New staff also received an induction at a local level. The induction of bank staff took place through a trust in-house team. Bank staff could access trust training.
- Lead nurses monitored the completion of mandatory training, as well as staff supervision and appraisals at the service's monthly improvement, quality and safety meeting.
- 93.3% of staff had received an annual appraisal in the previous 12 months. Training needs were identified as part of the appraisal and staff could request further training that was relevant to their role.
- All staff had an allocated supervisor and were receiving monthly 1 to 1 supervision. There was a supervision procedure and templates were role specific. Ward managers showed us the supervision dashboard. This recorded when staff received their supervision. The Cauzabon unit dashboard recorded that 96.9% of staff were up to date with monthly supervisions. The ward manager told us it was usually 100% of staff, but the figures had been skewed due to a member of staff being absent due to sickness.
- There were regular monthly team meetings. The ward manager on Fothergill ward showed us how the team used a book to record the minutes of team meetings. These were then typed and emailed to all ward staff. Staff told us they could consult the team meeting minutes book if they wanted to read the minutes before they had been emailed to them.
- Staff reported that they had received training on how to support people with dementia. Staff also had access to a tissue viability (TVN) nurse specialists and a link worker system for infection control. Staff received in house training for key skills such as catheter care. The lead nurse had a clinical day every Friday to support ward managers and clinical practice on the wards.
- Staff had access to regular training workshops. Upcoming training sessions included early on-set dementia, caring for leg ulcers and end of life care. Staff also had access to a range of e-learning.
- Competencies relevant to staff roles had been developed and there were systems to ensure competency was regularly reviewed. For example, nursing staff received competency assessments in medication administration.
- Nursing staff told us they were supported with revalidation; this is the process whereby nurses renewed their registration with the Nursing and Midwifery Council (NMC). Nurses' revalidation was a standard agenda item at community inpatients clinical governance meetings. Staff had work books related to their banding and role. The work books were completed by staff to support their revalidation and these were signed off by supervisors.
- Health Care Assistants (HCA) were encouraged and supported to complete the care certificate.

Multi-disciplinary working and coordinated care pathways

· The community inpatient service had a multidisciplinary approach to assessing, planning and delivering care and treatment to people who used services. This involved nursing, medical, therapy staff, social workers as well as GPs.

Good

Are services effective?

- There were regular multidisciplinary meetings. On both wards a visiting consultant from Newham hospital did a ward round and attended the weekly multi-disciplinary team meeting. There were lots of examples of multidisciplinary working, including close working with the dietician, community matrons and tissue viability nurse. The activities co-ordinator told us they worked with the occupational therapists and physiotherapists to adapt activities to assist patients' recovery, for example, craft work to improve fine motor skills.
- Staff told us community inpatient services benefitted from having input from a cardiac team, diabetes team, community mental health team, allied health professional teams including a range of therapies, as well as the local authority community adults' team and community mental health team. The service also had access to specialist nurses from the health centre on the East Ham care centre site.
- Community inpatient services held a weekly discharge meeting weekly. This was attended by medical staff from Newham General Hospital, therapists, and local authority social workers, to discuss patients who were being discharged and ensure their care needs were met. Therapists made visits to patients' homes as part of the discharge planning process, to assess the home environment for aids and adaptations, as well as assessing patients' ability to cope in the home environment.

· Social care staff were co-located with health professionals at the East Ham care centre which facilitated a joint approach to providing holistic care that met the needs of patients and their families and carers.

Referral, transfer, discharge and transition

- Referrals to community inpatient services were responded to within two working days. This was a key performance indicator. For the rehabilitation service discharge planning began when a patient was admitted to the ward.
- Admission to the wards was between 9.00am and 7.00pm. This ensured patients had an initial assessment completed that evening. Staff told us there were occasional admissions after 7.00pm but these were rare and usually due to delays in transporting a patient to the East Ham care centre.
- Community inpatient services admitted people seven days a week. Most referrals were from Newham General Hospital or the community based rehabilitation and reablement team. On Fothergill ward most referrals came from the acute hospital, with other referrals from a local hospice and the community. The service had fast-track access for continuing care patients approved through a continuing care panel. Initially admissions were for three months and then they were reviewed again to see if a longer admission of up to 12 months was appropriate. Patients that did not meet the criteria for continuing care would be referred to the local authority social work team who could arrange their transfer to either the community or a care home.
- The Cauzabon unit had three admission streams; admission avoidance; rehabilitation; and social care. The unit did not provide acute interventions, which meant patients had to be medically fit to be admitted. The expectation was that patients would be discharged within six weeks but some required longer rehabilitation and the service was flexible to meet this need. Staff told us they had not really had any inappropriate referrals but where patients' conditions had deteriorated they had been referred back to an acute setting. The unit liaised closely with discharge coordinators, reablement services, social workers, and GPs to ensure patients had access to appropriate care on their return to the community. Nursing staff also arranged transport for patients being transferred.
- Nursing staff followed up all patient discharges by telephone within 48 hours of discharge to ensure discharge care plans were being implemented appropriately,

Access to information

- Both wards used an electronic patient records system. Daily case notes and test results were recorded on the system, giving staff across the trust immediate and up to date access to patients' records. However, care plans and risk assessments were paper based. Staff said this meant assessments could be done at the bedside. Paper records we saw were up to date and written clearly.
- Staff on both the wards demonstrated how they could access all the information needed to deliver effective care and treatment in a timely way.

Good

Are services effective?

- Daily shift handovers ensured incoming staff received up to date information on patients.
- Staff told us the local GPs used a different electronic system to the community inpatient service system. Staff told us using two systems meant accessing people's information could be convoluted. This was identified as a risk on the Cauzabon unit risk register.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Overall, the service appropriately using the Mental Capacity Act (MCA) 2005 and code of practice. Staff were aware of their responsibilities in relation to the Mental Capacity Act and could describe how they applied it in their daily work.
- There was clear guidance including an easy to follow flow chart on the MCA and Deprivation of Liberty Safeguards (DoLS) on the trust intranet. Three patients on Cauzabon ward had a DoLS authorisation in place.
- The safeguarding team delivered training on the MCA and DoLS. The wards also had MCA champions. These were staff who had received extra training so that they could advise staff.
- Staff were documenting capacity assessments and best interest decisions. Ward managers on both wards gave us examples of best interest meetings that had been held when patients lacked capacity to make a decision for themselves.
- We found there were procedures in place for patients who lacked capacity to have access to an Independent Mental Capacity Advocate (IMCA) when serious decisions about their health and welfare needed to be made in their best interests. However, staff told us it was rare for people to use an advocate as most people who lacked capacity had a power of attorney in place or family members who could advocate on their behalf.
- On the Cauzabon Unit physiotherapists obtained and documented patient consent to treatment in additional areas such as exercise groups. Across community therapies patient consent forms had been signed by the patient or their relative and representative. We also observed staff on both the wards gaining verbal consent before providing care or treatment.
- On Fothergill Ward staff had recently met with a patient and their family to discuss a 'do not attempt cardiopulmonary resuscitation' form. The form had been signed by a doctor and the patient's power of attorney (POA).

Good

Are services caring?

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

We rated caring as **good** because:

- Patient dignity was observed in all interactions we observed.
- All patients we spoke with told us that staff were kind and treated them with respect. We did not come across any examples where this was not the case.
- Patients and relatives felt involved and included in their care and treatment.

Detailed findings

Compassionate care

- Staff were observed to be very caring taking in to account patients individual preferences and needs. For example, staff were seen sitting in the lounge area on the Cauzabon unit chatting with patients' as well as their visiting friends and family. On Fothergill Ward we observed staff providing sensitive care to patients receiving palliative care. Staff on the ward were caring and considerate in their interactions with patients and their families. Patients were supported to wear their own clothes, especially when participating in activities away from the ward.
- The Fothergill Ward's feedback from patients for June 2015 to April 2016 indicated that the ward had consistently achieved 100% for the question, "would you recommend the service to friends and family." The Cauzabon unit feedback results for the same period indicated that the ward had received a variable response between 60-100% to the question "were staff friendly and helpful". Patients, families and carers we spoke with were positive about the care and treatment they received from community inpatient services.

Understanding and involvement of patients and those close to them

- Patients and relatives were involved in decisions about treatment and care. Patients gave us examples of this such as being asked about pain and having things explained to them by doctors, pharmacists and nurses.
- Staff said they always celebrated patients' birthdays. We saw a patient on the Cauzabon Unit celebrating their birthday in the day room. The patients' family were involved in the celebration and had purchased food which was shared with other patients.
- Patients who were unable to or preferred not to attend activities were offered one to one sessions by the activities staff.
- Patients could personalize their rooms. We saw a patient's room on Fothergill Ward where staff had assisted a patient in making a life story board in their room, using photographs donated by the patient's family.
- There was a large amount of printed information available to patients across the community inpatient services we visited. Patients could also access information leaflets on the trust's website. There were extensive displays and leaflets covering condition-specific topics, general health advice and signposting to local health and social care services.
- Both the wards had 'you said, we did' boards on display on the wards. For example, Fothergill Ward had purchased recliner chairs in response to families requesting to stay overnight with patients.
- The trust were in the process of recruiting volunteers for a patient peer support initiative. This involved former trust patients volunteering to provide group and one to one support in inpatient wards.
- Community inpatient services held a focus group for patients and former patients to discuss improvements to the trust's continence services.
- Families and carers had a quarterly carers forum which was attended by the lead nurse. Families and carers could share their ideas and views on services.
- Fothergill Ward had a quarterly listening event for patients as well as ex-patients. The Cauzabon Unit had a listening event on a bi-monthly basis.

Emotional support

- We observed staff responding to people in a kind and compassionate manner. All the patients and carers we spoke with were positive about the emotional support the community staff provided. For example, a patient who was receiving palliative care told us they felt comfortable discussing their end of life care planning due to staff being understanding and compassionate.

Good

Are services caring?

- The activities co-ordinator told us that people receiving end of life care could receive a package of support from them, including playing music for the patient and family, talking with the patient and family, and ensuring they were available if the patient or family needed emotional support.
- Staff were aware of the emotional aspects of care for patients and provided specialist support for patients where this was needed. The relative of a patient on Fothergill Ward told us they were given information on counselling services by staff.

Good

Are services responsive to people's needs?

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

We rated responsive as **good**.

- Services were planned and delivered to meet people's needs with clear patient admission and discharge arrangements.
- The facilities met people's needs. For example there was a good programme of therapeutic activities.
- Services were meeting the needs of very vulnerable patients including those receiving end of life care.
- The wards tried to meet peoples' individual needs in terms of their disability, language, religion or culture.
- Information was available to support patients to make a complaint if needed and staff responded to any concerns promptly.

Detailed findings

Planning and delivering services which meet people's needs

- Both wards had a clear understanding of their role and how care would be delivered.
- Staff told us they worked with local service commissioners, including local authorities, GPs, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- Staff we spoke with told us they had developed good working relationships with other providers and stakeholders to ensure multi-disciplinary working and continuity of patient care. For example, a GP visiting Fothergill Ward told us there was good MDT working between GPs and the community inpatient wards.
- The model for medical cover at the Cauzabon Unit and Fothergill Ward was based on visiting consultants and registrars and GP cover from the response and reablement team.
- The East Ham Care Centre had an activities centre on-site, where patients could be involved in a variety of classes and activities including exercise. The activities centre included a sensory room, hairdressing salon and kitchen.
- Staff on Fothergill Ward told us the environment was limiting in terms of storage areas. However, following our discussion with the lead nurse, they told us this would be addressed as they would ask another provider on the ground floor to vacate space to give Fothergill Ward increased storage space for equipment.
- Staff also highlighted that some double rooms on Fothergill Ward posed problems for patients receiving continuing care. Staff said that this could be challenging for patients receiving end of life care, as double rooms could compromise the privacy and dignity of patients who were sharing rooms as well as their families.

Equality and diversity

- A number of initiatives were taking place to promote workforce race equality across the trust. There was a 'workplace allies' initiative to champion the rights of LGBT staff across the trust.
- Staff told us community inpatient services took a multi-faith approach and respected all religious festivals, reflecting the diversity of the local community.
- Staff we spoke with told us they have received equality and diversity training as part of the trust's corporate induction. Equality and diversity training updates were mandatory for all staff. Across community inpatient services 97% of staff had completed the training.
- Interpreters were available through a telephone interpreting service. Staff told us members of staff spoke many languages which reflected the diversity of the local population and staff could often help with communication. Staff told us interpreters could provide face to face services, but this needed to be booked. There was a flow chart on both wards with information for staff on how to access the 24 hour interpreting service by telephone. Staff told us all of the trust's printed information was available upon request in any language from the trust's accessible communications team.
- Staff told us they could access braille or large print documents.

Meeting the needs of people in vulnerable circumstances

Good

Are services responsive to people's needs?

- Staff told us they had found that community inpatient services cared for some of the most frail vulnerable patients in the trust.
- Staff told us the trust's learning disabilities team provided a range of services for people with a learning disability. Staff told said the team could provide a range of leaflets in easy read format upon request.
- Staff told us people with a sensory impairment had access to the trust's sensory services team.
- Staff told us dementia awareness training was mandatory for all staff..

Access to the right care at the right time

- Staff explained that the age at which patients would be accepted in community inpatients had been extended in 2015 and was now from the age of 50 years old.
- The average bed occupancy across the community inpatient service between August 2015 and January 2016 was 59.8%, the average by ward was 70.8% at the Cauzabon unit and 48.7% at Fothergill ward.
- Staff told us that waiting times for a bed were a rare occurrence and new patients could usually be admitted within two days of referral. Staff said this was due to community inpatients having the ability to step beds up or down in response to increases or decreases in demand. The trust had a bed management team who had oversight of bed availability across the trust.
- On Cauzabon ward we found that 'length of stay' meetings took place where all patients were looked at individually and any delay to treatment was discussed and escalated as appropriate. Cauzabon wards usual length of stay for rehabilitation was six weeks. The ward manager told us some patients stayed longer, but that this was usually for social care reasons.
- Fothergill Ward had a length of stay could be between a few days to over a year as the ward provided respite and continuing care. Staff told us patients initially came to the service for three months. But this could be extended for a further 12 months based upon the patient's eligibility for NHS continuing care.
- The lead nurse received a daily bed occupancy report. This enabled them to monitor the availability of beds across community inpatient services.

Learning from complaints and concerns

- On both wards and at the main reception the information boards displayed the complaints and compliments procedure including how to access the patient advice and liaison service.
- Staff had access to an easy read complaints policy for people who required information in this format.
- Community inpatient services had received no formal complaints from 1 January to 31 December 2015. The service had received 15 compliments during the 12 month period.
- Inpatient services attempted to resolve complaints at the earliest opportunity. Ward managers told us they investigated patient complaints immediately to ensure patients understood their concerns were being taken seriously.
- The monthly staff meetings looked at issues that had been raised by patients.

Good

Are services well-led?

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

We rated well led as **good** because:

- Staff told us they had confidence in their local leadership, who they found responsive and members of the executive team were visible.
- There was a governance structure that enabled managers and senior managers to appropriately monitor and review the quality of the service.
- There was engagement with staff in the form of staff awards and 'away days'
- The QI strategy promoted service improvements.

Detailed findings

Service vision and strategy

- Staff were also able to articulate the trust's values of 'we care, we respect, we are inclusive'. Both wards had formulated their own values and aligned these with the trust values. The ward manager of Fothergill Ward was in the process of producing a values display board which was aligning how staff behaviour would reflect the trust values. The lead nurse told us the QI programme was reviewed at community inpatient away days where staff looked at how they were achieving the strategic goals.
- The trust had a nursing strategy 2015-2018. Staff showed us copies of a handbook the trust had produced and disseminated to staff that clearly defined the trust's four care priorities.

Governance, risk management and quality measurement

- Wards had regular team meetings which discussed information from the directorate quality assurance meeting such as learning from incidents and complaints. Ward managers had access to management information, in a clear format which informed their management decisions. The wards completed their own risk register which fed into the directorate and trust wide risk register.
- The trust's QI programme had promoted the measurement of quality of care in the wards. For example, at the monthly 'improvement, safety, and quality' meetings there were standard agenda items including looking at incidents and complaints and also progress with a QI project looking at improving diabetes care for patients.
- Each service completed their own audits. For example audits of the completion and quality of patient assessments and care plans. The results were reviewed at a monthly manager's meeting monthly attended by all matrons, ward managers and senior nurses.

Leadership of this service

- Ward managers and staff felt confidence in the leadership of the community inpatient services. Staff told us that directors and the chief executive were visible.
- Staff also told us about the chief executive and directors had regular 'walk about' sessions. These involved members of the trust board visiting services and speaking with patients and staff.
- The lead nurse and ward managers had access to leadership training.
- Local team leadership was effective and staff said their direct line managers were supportive. Therapy staff told us their line managers were supportive and accessible.
- Staff told us the ward manager at Fothergill Ward provided outstanding leadership. This was supported by comparatively high rates of staff retention in comparison to other trust services.

Culture within this service

- Staff we spoke with were positive about the organisation, their teams and their work. Staff reported that morale was high across community inpatient services.
- All the staff we spoke with felt there was a very open and transparent culture in community inpatient services.
- Staff told us they were consulted on how they felt and what they would like to change.

Good

Are services well-led?

- Valuing staff was promoted. In team meetings if staff had done something outstanding it was recognised in team meetings. The trust also had 'unsung heroes' awards where staff who went 'above and beyond' in their work could be nominated by colleagues.
- "You said, we did," allowed staff to feel empowered to make changes.
- There were mechanisms in place for whistleblowing.

Staff engagement

- Staff were very engaged with the work of the trust through the QI projects.
- Staff had access to 'away days', these were days where staff could look at team performance.
- Staff told us they received regular newsletters via email. Staff also received a three monthly magazine 'Trust Talk'.

Innovation, improvement and sustainability

- Cauzabon Ward had received funding as part of the QI programme to purchase red socks and slippers to reduce falls risks to patients. The ward had also received funding to purchase polo shirts for healthcare assistants as well as nursing shirts. This was introduced linked to research the team had done into patients responses to mobilising. The team had found that patients mobilised more independently when healthcare assistants wore polo shirts similar to those worn by therapists.
- The Cauzabon unit had introduced the occupational therapy breakfast club. Patients could attend the club to practice mobilising in the kitchen and extend their food preparation skills.
- The trust was involved in a national pilot project about culture and leadership in the NHS, this was a two year programme looking at how trusts could provide high quality safe and compassionate care.
- The diabetes specialist service had been involved in a serious mental illness and diabetes pilot scheme with a local university. The service was waiting for information on the outcomes of the scheme.
- Community inpatient services had received a visit from the Institute of Healthcare Improvement in June 2016, who had sent delegates to look at a variety of health care models. This also gave staff an opportunity to consider what could be learnt from these exchanges. Staff told us the initiative was recent and had not been reviewed, but ideas would be fed back to the trust board.