

Good 

North East London NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RATY1	Sunflowers Court	Picasso Ward	IG3 8XJ

This report describes our judgement of the quality of care provided within this core service by North 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 North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as **good** because:

- There was evidence of good medicine management and patients medicine records were clear and accurate. The pharmacy team reviewed medicine charts including antipsychotic medication. Staff recorded patients allergy status on the prescription charts. Staff recorded where patients self administered medicines.
- Comprehensive and holistic care plans demonstrated patient involvement. Patients and carers were involved in care planning and care plans were written in a person centred way.
- Patients' physical health was assessed and regularly monitored by staff. Patients' physical health was discussed and reviewed during ward rounds.
- We saw kind and caring interactions between staff and patients. Patients told us that staff were polite and respectful. Staff were knowledgeable about patient needs. There was evidence of family and carer involvement in care planning.

- There was evidence of discharge planning in patient records. Staff discussed discharge planning with patients, families, carers and community services.
- Staff received regular supervision and appraisals. Staff received monthly supervision which could be increased if appropriate or requested. We saw evidence that all staff had completed their annual appraisal within the preceding 12 months.

However:

- We saw high use of bank staff, although regular bank staff was used where possible.
- There was no dedicated psychology input on the ward. However, staff could refer patients for psychological interventions. Staff told us there was a long waiting list and referrals were not based on wards although patients were fast tracked where possible.
- Patients were unable to make a drink or snack as required.
- Staff and patients expressed anxiety regarding the planned ward closure.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as **good** because:

- The ward was clean and tidy and furniture was appropriate and well maintained.
- The ward had separate sleeping and bathing areas for men and women that were compliant with Department of Health guidance on same sex accommodation.
- The clinic room was spacious and fully equipped with evidence of regular checks of medical devices and emergency equipment.
- Risk assessments were comprehensive and detailed and risk was reviewed regularly including during the ward round.
- Staff managed medicines well and medicine records for patients were clear and accurate.
- There was a good track record of safety on the ward and staff held regular meetings to discuss patients and risk.
- Staff had completed safeguarding training and knew how to make safeguarding alerts.

However:

- The environmental suicide and ligature point assessment action plan was dated 20 March 2015 and recorded a number of outstanding action points. The ward manager told us that repairs were delayed due to the trust not owning the building and relying on the property owner for repairs. The planned closure of the ward and low risk profile of current patients added to the lack of urgency. Staff were mitigating risk through observation and patient risk assessments.
- There was a high use of bank staff due to the trust not recruiting to vacancies because of the planned closure of the ward.

Good



Are services effective?

We rated effective as **good** because:

- We reviewed all patients' care plans and found them holistic, recovery focused and person centred.
- Clinical staff comprehensively assessed patients admitted to the ward. This included a good assessment of people's physical health needs, which staff regularly monitored and discussed.
- There was a range of professionals working on the wards including an occupational therapist, nurses and doctors.
- Regular team meetings took place where discussions included training, safeguarding, incidents and audits.

Good



Summary of findings

- We saw effective handovers taking place where staff discussed each patient.
- Staff were experienced and qualified and actively participated in clinical audits including care records, consent to treatment and missed doses.
- The trust had an electronic system for recording and storing information about the care of patients.
- Staff used the Mental Health Act (MHA) and accompanying Code of Practice correctly, MHA paperwork for patients subject to detention was in place and correct.

However:

- There was no dedicated psychological support on Picasso ward. However, staff could refer patients for this intervention, although there was a long waiting list.

Are services caring?

We rated caring as **good** because:

- We observed kind, caring and compassionate interactions between staff and patients. Patients told us that staff were polite and respectful.
- We saw evidence of family and carer involvement in patient care.
- Staff were knowledgeable about their patients' care and treatment needs.
- Advocacy information was displayed on the ward and patients' told us that staff supported access to this service.
- There was a weekly community meeting on the ward where patients were able to give their views and staff gave feedback in a 'you said we did' format.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- Staff discussed discharge plans with patients and their families. We found evidence of discharge planning with services in the community.
- There was a good range of rooms available for quiet time and activities. There was a range of activities and patients were involved in suggesting activities during the community meeting.
- There was a weekly social outing for patients, which included visits to the cinema, museum or bowling.

Good



Summary of findings

- Interpreters were arranged for patients where English was their second language. We observed an interpreter involved in the ward round during our inspection.

However:

- Patients were unable to make hot drinks when they wanted.

Are services well-led?

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

- Staff completed mandatory training, which was monitored at a local and trust level.
- There was 100% compliance for staff receiving supervision and appraisals.
- Staff had 'lead' roles on the ward and were involved in clinical audits including care planning, infection control, and consent to treatment and missed medicines.
- Incidents and complaints were discussed during handovers and in team meetings.
- Staff described good morale and team working on the ward.
- Staff said that they felt supported by their immediate line managers and could tell us who the senior managers were.
- Picasso ward was participating in the Safewards initiative.

However:

- Staff were concerned about the lack of information regarding the trust's planned closure of the ward.

Good



Summary of findings

Information about the service

Picasso ward is the rehabilitation ward for adults of working age with long-term mental health problems and those who may have a secondary diagnosis of substance misuse. Patients using this service require a longer period of inpatient treatment to fully recover. The rehabilitation service supports people to function to the best of their abilities, with the aim of returning to community living.

Picasso ward is a mixed gender ward for up to 15 people, there were 11 patients on the ward at the time of our inspection. The service usually admits people from the acute in-patient ward at Sunflowers Court who are aged between 18 and 65 years old.

The trust was last inspected by CQC in October 2015. This was a follow up visit to the December 2014 inspection

where areas of concern were identified at Sunflowers Court. The concerns were regarding high dose antipsychotic prescribing and its monitoring, as well as the risks associated with over sedation. In response to these concerns, the trust devised an action plan to address this. This included updating the high dose antipsychotic prescribing policy, which was circulated to staff for immediate implementation in all North East London Foundation Trust (NELFT) mental health inpatient wards. The trust conducted a follow up audit in June 2015 for all wards at Sunflowers Court to ensure staff had implemented the policy, which concluded that the areas of concern had been addressed.

Our inspection team

The team was led by:

Chair: Helen Mackenzie Director of Nursing Berkshire Healthcare NHS Foundation Trust

Head of Inspection: Natasha Sloman, Care Quality Commission

Team Leader: Louise Phillips, inspection manager, Care Quality Commission

The team that inspected the long stay rehabilitation ward comprised one CQC inspector, two nurse specialist advisors and one expert by experience.

A Mental Health Act Reviewer also visited the service during the inspection.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at a focus group.

During the inspection visit, the inspection team:

Summary of findings

- visited Picasso ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the manager and deputy managers of the ward
- spoke with six other staff members; including doctors, nurses and an occupational therapist
- attended and observed a hand-over meeting, a ward round, a mutual support meeting and a recovery group meeting
- carried out a specific check of the medicine management on the ward
- reviewed 11 medicine charts
- reviewed 11 care plan records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with six patients who said that staff were polite and friendly and involved them in planning their care. One patient told us that 'If the service wasn't here I don't think that I would be sitting here talking to you'. Patients said that staff treated them with dignity and compassion and that the ward was a comfortable and relaxed space. Five of the six patients told us that the food was good and that there was a menu choice.

However, two patients told us that they could not make drinks or snacks when they wanted and that their escorted leave was sometimes cancelled.

Areas for improvement

Action the provider **SHOULD** take to improve

Action the provider **SHOULD** take to improve:

- The trust should remove the broken pay phone on the ward in line with the environmental suicide and ligature point assessment action plan.
- The trust should ensure that patients have timely access to psychology.
- The trust should review the blanket restriction concerning staff searching all patients.

North East London NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Picasso Ward	Sunflowers Court

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

Mental Health Act (MHA) training became mandatory for staff in November 2015. Data provided by the trust showed that 13 staff on Picasso ward had completed training in the MHA, although no staff had completed the refresher training. If staff needed advice and support, they would contact the trust MHA office.

We saw evidence that staff routinely explained a patient's rights on admission to the ward and subsequently. However, staff had not discussed the rights of one patient for six months. We saw information regarding independent mental health advocacy services and evidence that staff supported patients to access this service.

MHA documentation was received and scrutinised by the qualified nurse in charge of the shift but there had been no new admissions for some time due to the planned closure of the ward. There were copies of consent to treatment forms accompanying the medication charts.

The section papers of detained patients were stored on an electronic archive system, which was accessed through, but separate from, the electronic patient record system used by the ward. This made it quite difficult for staff to access the documents. The section papers were available to view in the MHA administrators' office and were all present and correctly completed. Many of the patients had been detained for some considerable time and the MHA office file contained the relevant paperwork to track back through section renewals and community treatment order (CTO) revocations.

Detailed findings

Patients were supported to apply to Mental Health Tribunals and Managers' Hearings. Copies of the outcomes

of these hearings were kept in the MHA office and uploaded onto the archive system. The patients we spoke with were aware of their legal status and their rights concerning leaving hospital.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had 100% compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards training. Staff from all disciplines were able to explain to us the principles of the Mental Capacity Act (MCA). Staff were aware who to contact in the trust for advice and support.

We saw evidence that staff assessed a patient's capacity on admission to the ward, which was reviewed during the ward round.

The care records we reviewed included reports and notes which showed staff understood how to assess and document patients' mental capacity to make specific decisions, for example in relation to risk of exploitation of financial abuse.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The ward was clean and spacious with three corridors of five bedrooms each. The nurse's station was situated so that it overlooked the community area and had a reasonable view of the three corridors, which were to the left, right and in front of the nursing office. Three of the bedrooms on each corridor were ensuite. There was one shared shower/toilet, one shared bathroom/toilet and one toilet on each corridor. One corridor was for women only and all the rooms were occupied during our visit. This corridor also had a female only lounge. There were three male patients accommodated in each of the other two corridors. The rooms contained ligature points, which were not due to be removed. Risk was mitigated through observation and supervision although staff had assessed the patients as low risk for self-harm. The viewing panels on the bedroom doors could not be opened or closed from the inside, which potentially compromised the privacy of patients.
- The ward had staff offices and a staff room, a room which was used for ward rounds, a quiet room, a games room with a pool table and table football, a television lounge, a dining room and a locked kitchen. There was limited visibility to the activity room and dining room. Staff mitigated risks in these areas through observation and supervision.
- The clinic room was a good size and contained appropriate equipment including a couch and an electrocardiogram (ECG) machine. The room contained a controlled drugs (CD) cupboard with a book to record CD drugs kept on site. Resuscitation equipment was available which recorded staff completing daily checks. Staff checked the fridge temperature regularly. However, the temperature of the room was very warm at 26 degrees on the day of our inspection, which was above the maximum recommended temperature of 25 degrees. The pharmacist stated that this had been referred to managers to action.
- We saw a ligature risk assessment for the ward. However, this had been completed on 20 March 2015

meaning that information was not up to date. Staff had identified a number of areas on the ward, which required action and/or repair and action plans had been put in place by the trust to either manage or eradicate these risks. The ward manager told us that the building was not owned by the trust and therefore repairs were reported to the property owner of the building. Staff mitigated risks through observation and supervision of patients.

- We saw up to date cleaning records, which documented that the environment was regularly cleaned. In the 2015 Patient-Led Assessment of the Caring Environment (PLACE), Sunflowers Court where Picasso was located scored 100% regarding cleanliness of the environment, which was nearly 2% higher than the national average. We saw documented infection control audits for December 2015 and March 2016.

Safe staffing

- The ward had their staffing establishments estimated using the trust safe staffing tool and available budget. The planned daily establishment for each ward was four staff for the early shift, four staff for the late shift and three staff at night (4-4-3). Each shift consisted of two qualified staff and two health care assistants during the day and one qualified staff and two health care assistants at night. However, we found a high level use of bank staff on Picasso ward although regular staff were used where possible. We looked at rotas week beginning 4 April to 10 April 2016 and found that bank staff had been used in excess of 100 hours. Data provided by the trust documented that bank or agency staff worked 5121.83 hours of 18594.08 hours between September 2015 and February 2016. This equated to 28% of cover provided by bank or agency staff during this period. The trust kept a spreadsheet detailing the requests for bank staff, which included reason for the request. We saw that a number of requests related to escort, extra clinic, psychiatric emergency team cover and additional staff to carry out observations.
- Staff told us that there were three staff vacancies on the ward and that the trust was not recruiting to these posts due to the planned closure of the ward. In addition to the core staffing, an occupational therapist was

Are services safe?

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available 26 hours per week who provided activities for patients. However, there was an additional pressure on staffing due to one member of staff each shift being assigned to the psychiatric emergency team which provided support in the event of an alarm being raised in Sunflowers Court.

- The establishment level for whole time equivalent (WTE) qualified nurses was six band five nurses.
- The establishment levels for nursing assistants were four WTE band two, one band three and two support time recovery (STR) workers.
- The number of WTE vacancies for qualified nurses was two band five nurses.
- The number of vacancies for nursing assistants was one band two worker.
- The number of shifts filled by bank staff in the previous week to our inspection was in excess of 100 hours.
- There was a 5% sickness absence for nursing staff in the twelve months up to 31 October 2015. There was a 24% sickness absence for doctors in the twelve months up to 31 October 2015. The ward manager told us that most nursing staff sickness was mainly short term, and referrals were made to occupational health where appropriate. A band five nurse and band two nursing assistant had retired in March 2016. The ward manager was able to speak with the modern matron to authorise increased staffing levels.
- The regular locum consultant for the ward had left the week before our inspection. We were told that a permanent consultant had been recruited and was due to start employment in May 2016. We spoke with a consultant who told us that he was providing support to Picasso ward in the interim period and that a staff grade doctor was attached to the ward.
- The trust had their own bank staff, which were used wherever possible. The trust had a working time directive, which flagged up if staff were at risk of working in excess of 60 hours. We were told that occasionally bank staff were unable to start before 17:30 and that staff covering the day shift would stay later to ensure that there was sufficient staff for the ward.
- The trust had arranged for four floating members of staff for each shift to be available in the hospital making 12 extra staff per day. These staff were in excess of allocated numbers of staff per ward. The floating staff reported to the duty nurse who identified which wards were short staffed. Each ward booked these additional staff on rotation to share budget responsibilities. However, we were told that staff had raised concerns with the trust that some staff became reliant on the floating staff for cover.
- Staff and patients told us that escorted leave might be affected or cancelled because of lack of cover or bank staff not knowing the patient. However, staff told us this was avoided where possible.
- We saw evidence of regular physical health interventions in care records. Staff told us that there was a big focus on improving physical health for patients', which we observed during the ward round where physical health was discussed and reviewed. We witnessed a good dialogue between staff and patients concerning cardiac health, diabetes, anti-psychotics and obesity. The ward was involved in commissioning for quality and innovation (CQUIN) to improve physical health for mental health patients, which had involved the consultant and the trust's IT department designing a form which had been incorporated onto the electronic records system. There were seven main areas of physical health reviewed with patients which included smoking, alcohol use, drug use, blood pressure, weight, glucose and cholesterol. This form was found on the front page of the ward electronic records and staff could not save or close the form until all fields had been completed.
- The trust had an on call doctor based at Goodmayes hospital available during the day. There was a junior doctor, a senior trainee doctor and a consultant on call if required out of hours.
- Details provided from the trust showed that staff compliance with mandatory training averaged at 94% on Picasso ward. The ward clerk monitored training using a spreadsheet and flagged up to staff when training was due or overdue. Staff could access training details and dates on the trust intranet and request a place on required training. Staff compliance with mandatory and statutory training was:
 - Immediate Life Support - 91%
 - Equality and Diversity - 100%
 - Fire Safety Awareness - 78%

Are services safe?

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- Health & Safety Awareness - 89%
- Infection Prevention and Control - 94%
- Mental Capacity Act & Deprivation of Liberty Safeguards - 100%
- Information Governance - 100%
- Safeguarding Adults Recognition and Referral - 100%
- Safeguarding Adults Enhanced - 100%
- Safeguarding Children 2 - 89%
- Prevention and Management of Violence and aggression - 79%
- Prevent 1 - 100%
- Prevent 2 - 100%

Assessing and managing risk to patients and staff

- There was no seclusion room on the ward and the trust reported no incidents of seclusion or long term segregation used in the last six months on Picasso ward.
- The trust reported three incidents of restraint used between April and October 2015 on Picasso ward and no incidents of prone restraint used during this time. Staff told us that they rarely used restraint and when restraint was used, it usually related to patient's substance misuse. Staff told us that they used de-escalation techniques including talking to patients, time out and going outside with patients for fresh air to avoid using restraint.
- Staff completed risk assessments using the electronic records system, RIO. We reviewed the risk assessments for all 11 patients on Picasso ward which were detailed and comprehensive. Staff reviewed risks during the ward round. All patients had been risk assessed and general hourly observations were sufficient for patients. However, the level of observation could be increased if necessary, although this was rare.
- Patients were searched on admission to the ward and following unescorted leave. Staff told us they searched patients in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender. Staff said that they very rarely had a patient who refused to be searched, but should this occur a 'sensible' approach would be taken and staff would calmly and respectfully explain the reason for the search.
- Information was displayed on the ward advising informal patients of their right to leave and staff

regularly discussed rights with patients'. We spoke to an informal patient who told us they were aware they could leave at will and five of the six patients we spoke to told us they were aware of their rights.

- Staff had 100% compliance with Safeguarding Adults Recognition and Referral and Safeguarding Adults Enhanced training and 89% compliance with Safeguarding Children. Staff we spoke to were able to demonstrate knowledge and understanding concerning safeguarding and when a referral should be made. There was a clear process for raising alerts and reporting to the trust's safeguarding team, the community teams and the local authorities. The trust had a safeguarding lead who occasionally visited the ward. Staff gave us examples of safeguarding alerts that had been raised over the last few months. For example, staff had raised an alert following concerns about a patient possibly posing a risk to children in their family. We found evidence of staff completing safeguarding alerts and meetings taking place in response to these alerts. However, no safeguarding alerts had been sent to CQC between 1 January 2015 and 18 February 2016.
- We reviewed the medicine prescription charts for all eleven patients on Picasso ward. All charts were clear and legible, patients' allergy status was recorded and records showed that medicines were administered as prescribed. Pharmacy staff reviewed the charts and had made comprehensive records on the prescription charts to guide staff in the safe prescribing and administration of medicines, including antipsychotic medication. For example they ensured that tests were carried out to check whether certain medicines were adversely affecting liver function. Some patients were prescribed clozapine which required regular monitoring to make sure the correct dose was prescribed. We saw that the trust had a process in place to make sure the blood tests were carried out as needed. We saw good evidence of medicines being prescribed for a variety of physical health issues. Staff recorded self-administration of medicines. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital. However, staff did not attach a photograph of the patient to ensure that medicines were administered to the correct patient or indicate the legal status for

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detained patients other than attaching T2 and T3 paperwork to document consent to treatment and / or certificate of a second opinion, to the prescription card for ease of reference.

- Staff followed the trust policy concerning children visiting the ward.

Track record on safety

- No serious incidents had been reported between 1 November 2014 and 31 October 2015 for this service.

Reporting incidents and learning from when things go wrong

- Incidents were reported using an electronic incident reporting tool. Staff we spoke with were clear on the process for reporting incidents and concerns. Nursing and care staff were able to cite examples of incident reviews that had been discussed in team meetings. We saw evidence that incidents were discussed during handover meetings. The ward manager told us that incidents were discussed during a monthly manager's meeting and weekly matron meetings. Staff told us that following an serious incident, the trust sent an email to all staff including action points and lessons learnt.

Are services effective?

Good 

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.

Our findings

Assessment of needs and planning of care

- We reviewed the care records for all 11 patients on Picasso ward. Staff had completed a comprehensive and timely assessment following admission to the ward. All patient care records were present and up to date. The care plans were personalised, holistic and recovery orientated. Patients were involved in their care planning and care records were written in a person centred way, and staff had given patients a copy of their care plan. Staff completed a physical examination for patients and physical health was monitored during ward rounds. We observed staff discussing daily living skills with patients during the ward round.
- All information relating to patients' was stored on the electronic records system (RIO). The ward clerk scanned paper work that was completed outside of RIO onto the patients' record using 'Windip'. This system was accessed through, but separate from, the electronic patient record system, which made it difficult for staff to access documents stored there.
- The ward and trust were smoke free and staff offered patient's smoking cessation and nicotine replacement therapy.

Best practice in treatment and care

- The National Institute for Health and Care Excellence (NICE) guidance CG123 "common mental health disorders: Identification and pathways to care" and CG178 "psychosis and schizophrenia in adults: treatment and management" recommends that the psychological therapies of cognitive behavioural therapy (CBT) and interpersonal psychotherapy are available for patients. We found that there was no dedicated psychology therapy available on the ward. We were told that the ward had previously been able to provide this service but this was not replaced due to the planned closure of the ward. However, staff told us that they could refer patients for psychological support, but there was a long waiting list.
- We saw evidence of comprehensive monitoring of physical health care during ward rounds, which included discussions concerning weight management, nutrition and exercise. We reviewed clinical entries

recorded for ward rounds, which were detailed and comprehensive. Staff used modified early warning score (MEWS) to monitor patients physical health, which were completed weekly as a minimum. The consultant told us that the staff grade doctor assessed patients' physical health and would refer to the local hospital if specialist medical care was required. Staff liaised with general practitioners regarding non-emergency care. We saw evidence of a good working relationship with the nearby King George hospital. We reviewed a comprehensive audit concerning the high use of antipsychotics where the trust had identified and actioned areas of learning.

- The occupational therapist had created a comprehensive programme of activities in response to peoples assessed needs, which included a recovery group and mutual help group. The occupational therapist had completed a patient survey regarding groups and was planning to start a working group. Information sessions included the trust pharmacist delivering managing medication groups and discussions with the trust dietician. The occupational therapist completed activity return forms for groups to identify what and how many activities had been delivered.
- Staff were involved in clinical audit including care records, infection control and consent to treatment.

Skilled staff to deliver care

- Staff on Picasso ward were an established team who had significant experience of working on long stay / rehabilitation wards. The multi-disciplinary team had a range of professionals that worked within this service, which included a consultant, a staff grade doctor, qualified nurses, occupational therapist, health care assistants and STR workers. We saw records of regular staff meetings for the ward. The occupational therapist provided activities five days a week. We were told that some activities were available at the weekend and were provided by therapists from other wards. A pharmacist visited the ward daily and was involved in the ward rounds and multidisciplinary team (MDT) meetings.
- We saw evidence that staff received regular one to one supervision and an annual appraisal in the preceding

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twelve months. Staff told us that the consultant and staff grade doctor had both completed their revalidation. Staff had access to specialist training which included diabetic nurse training.

Multi-disciplinary and inter-agency team work

- The ward held three daily handover meetings, which took place in the morning, afternoon and evening. Multidisciplinary (MDT) meetings took place every Monday and Tuesday and were attended by the consultant, ward doctor, care co-ordinator, staff nurse and occupational therapist. Families were encouraged to attend and the trust psychologist, pharmacist and interpreter would attend when appropriate. We observed a handover meeting attended by the two deputy ward manager's, the staff nurse and a health care assistant. Staff discussed all patients and used the ward round book for feedback and comments. Staff discussed patient presentation, capacity, self-medication and daily living skills during the meeting. Staff told us that there were effective working relationships with teams outside the organisation and staff from agencies including supported housing, benefits and substance misuse services attended MDT meetings. Regular liaison took place with social services concerning patients with identified safeguarding issues, which staff documented in patient records.
- We saw minutes of the monthly governance meeting which from October 2015 had been separated into items involving safe, effective, caring, responsive and well led.

Adherence to the Mental Health Act and the MHA Code of Practice

- All staff had completed Mental Health Act (MHA) training although staff had not completed the MHA refresher training at the time of our inspection. However, this training only became mandatory in November 2015. Compliance with staff training was monitored during supervision and the ward clerk told staff when training was due or overdue. The ward manager discussed staff compliance with training in the monthly manager's meeting.
- For people detained under the MHA (1983) we found that the required documentation for treatment for

mental disorder was in place. We saw that the pharmacist had recorded guidance on the prescription charts to make sure the prescription was within the authorised plan.

- The section papers for detained papers were held on the 'windip' system on the electronic records system which made it difficult for staff to access these documents. However, these papers were available to view in the MHA administrator's office and were found to be present and completed correctly. Many of the patients had been detained for some considerable time and the MHA office file contained the relevant paperwork to track back through section renewals and community treatment order (CTO) revocations.
- The trust had a MHA lead who staff could contact for support and advice. The trust lead delivered MHA training and refresher training for staff.
- MHA documentation was received and scrutinised by the qualified nurse in charge of the shift but there had been no new admissions for some time. There was evidence that a process was in place for explaining rights to patients when first admitted and repeating the explanation subsequently. However, we saw evidence that one patient had had no discussion of rights in the previous six months.
- There was evidence that staff had completed capacity assessments for all patients on admission, which were reviewed every week during the ward round. All the prescribed medicines were covered by the consent to treatment and / or certificate of a second opinion form T2 or form T3, where patients refused consent or were unable to give consent. The manager completed a monthly consent to treatment audit.
- Independent Mental Health Advocacy (IMHA) information was displayed on the ward and we saw evidence that staff helped patients to access the service. The IMHA representative did not hold a dedicated drop in clinic but did visit the ward regularly. Patients were supported to apply to Mental Health Tribunals and Managers' Hearings. Copies of the outcomes of these hearings were kept in the MHA office and uploaded onto the archive system.
- Leave was authorised through a standardised system and was appropriately recorded and included specified conditions. Patients were given copies of their leave

Are services effective?

Good 

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.

forms and their families were informed. However, patients informed us that escorted section 17 leave had been cancelled from time to time due to staff shortage. We spoke with a detained patient who said that they were aware that they were on a section and knew their rights. The informal patient we spoke to told us that they knew that they were an informal patient and had the right to leave.

Good practice in applying the Mental Capacity Act

- Staff on Picasso ward had 100% compliance with completion of the Mental Capacity Act (MCA) training. We saw evidence of staff assessing patients' capacity in electronic care records and during ward rounds.
- Data from the trust recorded staff completing one Deprivation of Liberty Safeguards (DoLS) referral between June and November 2015. The ward manager told us that staff usually use the MHA.
- The trust had a lead for MCA who staff were able to go to for advice and guidance when needed.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- We observed staff treating patients in a supportive, caring and compassionate way. We spoke with six patients who told us that staff were polite and respectful and they felt involved in their treatment. All patients except one told us that staff always knocked on their bedroom door before entering. We observed a mutual help meeting and a recovery group where the occupational therapist demonstrated compassion and knowledge of the patients.
- Privacy and dignity of patients was compromised where they could not open or close the viewing panels from inside their bedrooms.

The involvement of people in the care they receive

- We received mixed feedback concerning staff orientating patients to the ward and involvement in

their care. However, all patient's told us that their families were involved in their care. We saw evidence that patients, families and carers were regularly involved in care planning and decision making. We saw advocacy information displayed on the ward and evidence that staff supported patients to access this service.

- There was a weekly community meeting which was attended by patients and all staff. We observed the occupational therapist delivering the recovery group who demonstrated compassion and a working knowledge of the patient's needs. The occupational therapist made great efforts to engage a patient where English was their second language.
- All patients completed a recovery and wellbeing booklet with staff which included information such as wellness tools which made the patient feel safe, ambitions and dreams and triggers to feeling unwell.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- Data provided from the trust recorded 75% bed occupancy between May and October 2015 and no delayed discharges for the same period.
- The ward was not accepting new admissions due to the planned ward closure. The trust did not intend to open an alternate long stay rehabilitation ward. Staff told us that the trust had originally told them that the ward would be closed in March but had now been told that it would now probably close in August or September. Staff told us that the uncertainty caused anxiety for both patients and staff. Patients told us that they were aware of the planned closure of the ward and staff discussed this with them during patient one to ones and in groups.
- We saw evidence of discussions and liaison between staff, families and outside agencies regarding patient's discharge and staff had recorded discharge planning in all patient records. However, we saw evidence of problems regarding discharging patients from the borough of Barking and Dagenham because of funding issues for move on accommodation. Discussions concerning these issues were documented in minutes for community meetings which recorded efforts to seek support through the advocacy service.
- There was a nursing station with a patient board that was closed when not in use and working CCTV, which was a vestige of when PICU had occupied the ward. The ward had a treatment room and staff regularly checked equipment and medicines.
- There was a broken payphone on the ward and patients told us that this had not worked for about a year. The environmental suicide and ligature point assessment action plan documented a recommendation to remove the phone. We were told that patients could keep their own mobile phone and charger unless staff assessed risk as too high, although this was rare. Staff told us that if a patient did not have a mobile phone, they could use the telephone in the staff office, although a member of staff would have to remain with them.
- There was a menu choice for food and cultural needs were met. All patients except one told us that the food was okay. Patients were able to personalise their bedrooms and could ask staff to lock their door. One patient told us that the hospital had provided a safe for them. Patients were unable to make their own drinks or snacks. However, water was available in the dining room and staff provided regular refreshment breaks throughout the day.
- The occupational therapist (OT) had completed a patient survey regarding groups and was planning to start a working group. The OT arranged a weekly social outing for patients and included visits to the cinema, museums and bowling. The OT completed a daily activity form which recorded the time and type of activity provided. The OT assigned to the ward delivered regular activities during the week and a band four occupational therapist assistant supported weekend activities on the ward.
- Sunflowers Court, where Picasso was located, scored 88.1% for PLACE in relation to privacy, dignity and wellbeing, which is 2% higher than the national average.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had staff offices and a staff room, a room which was used for ward rounds, a quiet room, a television lounge, a games room with a pool table and table football, a dining room and a locked kitchen. Patients were unable to make a hot drink whenever they wished as the ward did not have an activities for daily living (ADL) kitchen. However staff brought regular hot refreshments to patients throughout the day.
- Patients had access to two outside areas during the day which were large and private where barbeques took place in the summer. One of the outside areas had a basketball court and could be used for other activities including football. The outside areas had high fencing which remained from when the ward had previously been a psychiatric intensive care unit (PICU).
- Meeting the needs of all people who use the service
- The ward had good disabled access throughout and was on a single level which was accessible from the rest of the hospital building without the use of steps, ramps or elevators.
- We saw that where possible people administered their own medicines, in preparation for leaving the ward.

Are services responsive to people's needs?

Good 

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

Some people were assessed as needing supervision, others were able to keep their medicines in their rooms with occasional checks from staff. We saw that this was recorded on the prescription chart so it was clear what level of support was needed. The trust provided medicines information sheets with basic information or more detail including side effects, depending on what patients wanted.

- Information concerning local services and advocacy was displayed on notice boards in the ward. We saw evidence of staff arranging interpreters for patients where English was their second language. An interpreter was involved in the ward round that we observed. Staff could request information leaflets in different languages if required. Information displayed on the ward included the names of staff on duty.
- The chaplain regularly visited the ward to speak with patients. Support could be arranged for patients for all spiritual beliefs and included visits to temples and mosques. Staff had recently arranged a communion for a patient at their request.

Listening to and learning from concerns and complaints

- The trust reported receiving no complaints or compliments between May 2014 and December 2015 for Picasso ward. Staff told us that comments or informal complaints received from patients were managed locally and discussed during handover meetings. We received mixed feedback from patients regarding how to complain. Three patients told us that they knew how to complain and felt confident in doing so; two patients told us they did not know how to complain and did not feel confident to do so and one patient told us that they were unsure how to complain and didn't like complaining. Community minutes documented comments and complaints as an agenda item and recorded staff advising patients about the CQC inspection and that patients would have the opportunity to speak with inspectors.
- There was a 'recovery tree' displayed on the ward for patients to leave comments and feedback before being discharged from the ward.

Are services well-led?

Good 

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.

Our findings

Vision and values

- The trust vision and values were displayed in staff rooms on the ward. The work of the ward reflected the organisations values and objectives, though ward staff were not always able to articulate them. All staff were dedicated to a high standard of patient care. The ward manager had regular contact with the modern matron and senior management. Staff told us they were aware who the senior managers were and that a senior manager had met with staff a couple of months ago to discuss the ward closure. However, staff told us that the trust had offered limited information of the ward's impending closure and the consequences of this for patients and staff.

Good governance

- All staff completed mandatory training which was monitored during supervision. The ward clerk monitored and recorded staff training on a spreadsheet which was discussed during team meetings. Staff were able to access training information and book onto events using the trust intranet. The trust also monitored staff attendance at training using a training matrix tool. The ward manager told us training was discussed at monthly manager's meetings.
- Staff had 100% compliance with completion of supervision and annual appraisals which was monitored by the ward manager. We saw supervision records which had a set agenda which could be added to. Staff told us that supervision took place monthly and more frequently if requested.
- Staff told us staff mix was appropriate and bank staff could be sourced when needed. However, this had to be requested through the modern matron. Staff told us that regular staff often worked longer hours so that there was sufficient cover on the ward before the bank staff arrived. Staffing sometimes affected the outside activities available for patients which were arranged around shift changes when more staff were available on the ward.

- Staff actively participated in audits and had identified 'lead' roles on the ward. For example, for infection control and care plan audits. Incidents, complaints and patient feedback were discussed during daily handover meetings and monthly team meetings. We saw minutes of the weekly community meeting where patients were able to discuss complaints and feedback regarding the service. The ward manager told us that Picasso ward had no discharge key performance indicators (KPIs) due to the planned closure of the ward. There had been no new admissions to Picasso ward since October 2015. The ward manager told us that he had sufficient authority and admin support.
- The trust risk register was discussed during the health and safety meeting.

Leadership, morale and staff engagement

- Staff told us that they felt supported by the ward manager and had a good working relationship with colleagues. However, they felt anxious regarding their future due to the limited information received from senior managers concerning the closure of the ward. A senior manager had met with the team some time ago and asked for ideas regarding the future of the service. However, staff had not received a formal update since this meeting.
- The consultant covering the ward told us that senior management had identified concerns regarding staff engagement in the trust and arranged a staff morale survey and ten small staff engagement workshops for staff. Inspectors saw a one page newsletter that the trust had introduced in an attempt to improve communication with staff.
- Staff told us that specialist training and development was discussed during supervision.

Commitment to quality improvement and innovation

- Picasso ward was participating in an initiative called 'safewards' which has a number of modules in which the patients and the staff work together with the aim of making the ward a safer and calmer environment. The modules look at things such as mutual expectations, calm down boxes, soft words and mutual help meetings.