The Raphael Medical Centre

Quality Report

Raphael Medical Centre
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Raphael Medical Centre (RMC) on the 24 and 25 November 2015 and 7 December 2015. This was a comprehensive inspection of the location carried out as pilot for our methodology for inspecting long term conditions services. As this was a pilot inspection, we did not rate the service.

The RMC is an independent hospital mainly specialising in the neuro-rehabilitation of adults suffering from complex neurological disabilities with cognitive and behavioural impairment.

There are facilities to accommodate a total of 47 patients. There is space for 33 patients in two wards in the main building, nine patients in Tobias House, which is a designated as an area for the treatment of prolonged disorders of consciousness. There is capacity to treat up to eight patients in the special care unit (SCU) for neuro behavioural rehabilitation and this unit also accommodates patients admitted under the Mental Health Act. At the time of our inspection there was a separate out-patient service specialising in the treatment of cancer.

Are services safe at this hospital?

We found safety was not a sufficient priority. There were insufficient arrangements to ensure staff received feedback from safety incidents or that learning points were identified and disseminated. We identified concerns in relation to the environment, arrangements to identify and support patients whose condition is deteriorating, shortfalls in infection control procedures and issues with the supply and administration of unlicensed medicines. However, there were adequate arrangements for discharging responsibility of the Duty of Candour regulations, and staff were committed to a culture of openness and transparency. There was a safeguarding lead and staff understood their responsibilities in the safeguarding of vulnerable people. Staffing levels for doctors, nurses and therapist met published guidance from the British Society of Rehabilitation Medicine (BSRM) and overall there were arrangements for the safe handover of patients between staff at the hospital and other services.

Are services effective at this hospital?

In the outpatient service, there was insufficient assurance to demonstrate people received effective care based on current evidence-based guidance, standards and practice. There was no monitoring of people's outcomes of care and treatment. In the long term conditions service, we found that treatment generally followed current national guidance but there was no systematic gathering of data about outcomes of treatment for treatment or benchmarking of the effectiveness of care, although the hospital contributed data to the United Kingdom Specialist Rehabilitation Outcomes Collaborative (UKROC) . There were arrangements for the ratification of policies although we found examples where these has not been followed. The hospital had an Medical Advisory Committee, although this was not yet fully embedded. Medical staff had completed the required revalidation processes. Consultant medical staff were employed under practising privileges but there were no formal, documented practicing privileges agreements that set out the conditions and rules of that practice. We found that the service was compliant with requirements of the Mental Capacity Act 2005, including those relating to the Deprivation of Liberties safeguards (DoLS).

Are services caring at this hospital?

Patients and their relatives reported receiving care that was compassionate and respected their privacy and maintained their dignity. We saw many instances of care being delivered in this manner. Overall, staff provided adequate emotional support to patients and their relatives although we found examples where people's emotional and social needs were not always viewed as important or reflected in their care and treatment.

Are services responsive at this hospital?

The RMC liaised with other stakeholders to plan services to meet the specialist needs of the patient group they served. There were systems and arrangements to ensure that patients referred to the RMC were assessed as being suitable and

Summary of findings

safe for the care at the hospital with clear admission criteria. There were arrangements to ensure that waits for the service were kept to a minimum and that discharge from the service was planned and effective. Complaints were taken seriously, investigated and resolved but there were insufficient arrangements to ensure there was learning from complaints. The OPD service offered little flexibility to patients in the timing of appointments.

Are services well led at this hospital?

The governance arrangements and their purpose were unclear with ineffective arrangements for the systematic provision of assurance to the board. The governance arrangements did not adequately monitor performance and risks. Although staff told us they felt supported by their managers, the chief executive maintained control of every aspect of the hospital and was reluctant to delegate duties to the directors of departments resulting in a directive, "control and command" model of leadership. However, The RMC had a clear vision built around the anthroposophical image of man, which recognises man as being of body, soul and spirit. Staff demonstrated that they supported this philosophy of care. The hospital had an active research portfolio and had presented their findings in world conferences and had articles published in the professional press.

Our key findings were as follows:

- There was an insufficiently robust system of governance to monitor performance, and the identification and mitigation of risk. There were insufficient arrangements for learning from safety incidents.
- Department of Health's code of practice on the prevention and control of infections and related guidance was not fully complied with.
- Cleaning standards were not maintained to a satisfactory standard and there was no method of monitoring these. The physical environment did not comply with relevant government guidance (Health Building Notes).
- The hospital was not proactive in monitoring patient outcomes. There was no evidence of outcomes or benchmarking as a result of input into the national database (UKROC).
- Arrangements for end-of-life care and for advance care planning were insufficiently developed and there was lack of recognition of the value of this aspect of care.
- Arrangements for the supply and administration of unlicensed medicines did not meet current legislative requirements.
- Staffing levels met published guidance and were sufficient to ensure patients' needs were met. However, there were no formal practicing privileges agreements for consultant medical staff.
- Staff received adequate training which was mandatory, including in safeguarding and were competency assessed. They received an annual appraisal and had opportunities to develop their knowledge and skills.
- Patients could access care and therapy services at all times from a multi-disciplinary team who worked collaboratively between themselves and the patient.
- Patients were screened for the risk of malnutrition and received support to ensure their received adequate nutrition and hydration. There were arrangements to manage those who required artificial feeding.
- There were adequate arrangements for obtaining consent, and the Mental Capacity Act requirements were met for those unable to make decisions for themselves. Do not attempt cardio-pulmonary resuscitation (DNACPR) orders complied with national guidance although this was not formally audited.
- Patients and their relatives reported receiving compassionate and dignified care which generally met their needs.
- The hospital understood the needs of its specialised patient group. Access to care was timely with clear processes to ensure the suitability of refereed patients for admission, and effective discharge planning.
- Patients and their relatives had the information they needed and were supported to provide feedback or to make a complaint. Complaints were investigated and resolved although systems to learn from complaints were insufficient.
- The hospital had an active research portfolio with a national and international profile.
- Following our announced inspection we were informed the outpatient service had been closed with immediate effect.

Summary of findings

We saw several areas of outstanding practice including:

- The hospital was involved in a number of national studies relating to the treatment of people with acquired brain injury. The hospital was instrumental in developing, piloting and refining the Wessex Head Injury Matrix (WHIM) used in auditing outcome in prolonged disorders of consciousness.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that it provides feedback to staff regarding safety incidents and consider systems to ensure that there is appropriate learning from such incidents.
- Ensure all fire exits are wheelchair accessible and are not blocked and provide appropriate fire exit signage.
- Consider how it ensures that waste is segregated and stored to meet current guidance
- Consider systems to ensure the safety and quality of the water supply throughout the premises and in the hydrotherapy pool.
- Develop systems to ensure medicines are stored at the manufacturers' recommended temperatures.
- Have systems that ensure that equipment shared between patients is decontaminated after use.
- Develop schedules, risk assessments and monitoring systems to ensure the adequacy of cleaning arrangements.
- Conduct risk assessments when floor covering materials do not meet published specifications and consider the appropriateness of soft furnishings and seat covering material
- Consider the means of summoning emergency assistance in the art room.
- Ensure consultant staff have current practicing privileges in place.
- Have systems to ensure that all electrical equipment, including clinical equipment, is appropriately checked and maintained.
- Consider how it evaluates the effectiveness of care and benchmarks performance against other similar centres.
- Develop robust systems of governance, including risk registers and business continuity plans that mitigate identified risks.
- Make arrangements for the controlled drugs accountable officer role to be fulfilled according to guidance.
- Ensure all statutory notifications relating to safeguarding or Deprivation of Liberties Safeguards are reported to the CQC in a timely manner.

In addition the provider should:

- Consider how care plans reflect the spiritual and emotional needs of patients to guide staff in providing patient-centred care.
- Take action to ensure all goal setting meetings are documented.
- Take action that ensures patient records reflect the input of all health care staff treating the patient, including therapy staff.
- Make arrangements to provide information for staff, patients or relatives about prolonged disorders of consciousness and complex issues in Tobias House.
- Consider how an early warning system such as the National Early Warning Score (NEWS) could be used to comply with BSRM guidance.
- Make arrangements that ensure patients requiring replacement of artificial feeding tubes can be treated on-site at all times by staff with the required competency.
- Introduce systems to audit DNACPR documents and processes allowing learning from these.
- Review its policy and staff training with respect to end of life care in order to meet current guidance and best practice. Consider how the use of advance care plans could be used to enable patients to express future preferences.
- Ensure that there are arrangements to maintain the dignity of patients in the therapy room.
- Consider how management and leadership responsibilities and accountabilities can be delegated and shared by the senior management team.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

We found that that the service was not providing a safe, effective and responsive service. There were some concerns with the leadership.

Safety was not a sufficient priority. There were inadequate systems in place for staff to assess, monitor or manage the risks to people who used the services. We identified concerns in relation to the environment, arrangements to identify and support patients whose condition is deteriorating, shortfalls in infection control procedures and issues with the supply and administration of unlicensed medicines.

The governance arrangements and their purpose were unclear with ineffective arrangements for the systematic provision of assurance to the board. The governance arrangements did not adequately monitor performance and risks.

In the outpatient service, there was insufficient assurance to demonstrate people received effective care based on current evidence-based guidance, standards and practice. There was no monitoring of patients' outcomes of care and treatment.

In the long term conditions service, we found that treatment generally followed current national guidance but there was no systematic gathering of data about outcomes of treatment or benchmarking of the effectiveness of care.

The hospital did not fully acknowledge and provide for end of life care and advance care planning. The recognition for emotional support and spiritual needs of the patient was limited.

Overall, patients and their relatives experienced a caring and compassionate service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients and diagnostic imaging		We found that the outpatient service was not providing a safe, effective and responsive service. There were concerns abut the quality of leadership and some aspects of caring were not good. Safety was not a sufficient priority. There were inadequate systems in place for staff to assess, monitor or manage the risks to people who used the services. There was insufficient assurance to demonstrate people received effective care based on current evidence-based guidance, standards and practice. There was no monitoring of people's outcomes of care and treatment. The governance arrangements and their purpose were unclear with ineffective arrangements for the systematic provision of assurance to the board that risks were being adequately assessed or managed. The majority of patients we spoke with gave positive feedback about the way staff treated them but people's emotional and social needs were not always viewed as important or reflected in their care and treatment.
Long term conditions		We found the long term conditions service was not providing a safe, effective or responsive service. There were issues with the quality of leadership, but care was delivered in a caring way. We identified concerns in relation to the environment, arrangements to identify and support patients whose condition is deteriorating and shortfalls in infection control procedures. The hospital did not acknowledge the importance of end of life care, and advance care planning. The recognition for emotional support and spiritual needs of the patient was limited. The governance arrangements did not adequately monitor performance and risks. Patients and their relatives were positive about their experience of the care and the kindness afforded to them. We found that treatment generally followed current national guidance.

Summary of findings

Patients were cared for by a competent multidisciplinary team working in a cohesive way.

Summary of findings

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Raphael Medical Centre

Services we looked at
Long term conditions; Outpatient and diagnostic imaging services.

Summary of this inspection

Background to The Raphael Medical Centre

The Raphael Medical Centre (RMC) is an independent hospital mainly specialising in the neuro-rehabilitation of adults suffering from complex neurological disabilities with cognitive and behavioural impairment. The hospital states that its services are based on a desire to ensure that a peaceful and tranquil environment is created which helps people to move from a state of medical dependency to reach their optimum level of functional independence.

There are facilities to accommodate a total of 47 patients. There is space for 33 patients in two wards in the main building, nine patients in Tobias House, which is a designated as an area for the treatment of prolonged disorders of consciousness. There is capacity to treat up to eight patients in the special care unit (SCU) for neuro behavioural rehabilitation and this unit also accommodates patients admitted under the Mental Health Act.

The service principle is a holistic one based on the anthroposophical image of man, which recognises man as being of body, soul and spirit. Therapies include art, music, oil dispersion and physiotherapy. Facilities available at the hospital included a physiotherapy gym, a hydrotherapy pool, and therapy rooms, consulting rooms, dining room and common area.

Our inspection team

Our inspection team was led by Shaun Marten, Inspection Manager, Care Quality Commission.

The team included CQC inspectors, including a specialist pharmacy inspector and an inspection manager experienced in mental health inspection. The team include a variety of specialists including a consultant doctor and nurses and occupational therapists with expertise in acquired brain injury and rehabilitation and cancer services. Health services' managers joined the team and included one with experience of managing estates and support services. The team also included an Expert by Experience, a lay person with experience of using long term condition services.

Why we carried out this inspection

We carried out this inspection as part of a pilot of our methodology for long term conditions. As this was pilot, we did nor rate services at Raphael Medical Centre.

We inspected the outpatient service using our current methodology for outpatient and diagnostic imaging services for independent health care hospitals.

How we carried out this inspection

To help us understand and judge the quality of care for patients at the RMC we used a variety of methods to gather evidence.

The hospital provided us with information about the service, its governance arrangements and policies, and performance data prior to our inspection visit which we analysed. We also reviewed information we held about the RMC, including information from staff whistle-blowers, from patients' relatives and statutory notifications submitted by the RMC.

We provided facilities for patients and their relatives to submit comments before and during the inspection visits.

Summary of this inspection

We carried out an announced visit on the 25 and 26 November 2015 and carried out an unannounced visit on 7 December 2015.

We spoke with managers, medical staff, nursing staff, allied health professionals and support workers. We held focus groups for nursing and care staff, therapists and support workers. We also spoke with patients and their relatives.

We observed the care and environment, and looked at patient records, including patient care records. We looked at a range of documents, including audit results, action plans, policies and management information reports.

Following this inspection we referred concerns about fire safety management to the Mid-Kent Fire Safety Office for further action.

Following our announced inspection we were informed outpatients service had been closed with immediate effect. The registered manager reviewed the organisation's statement of purpose and removed reference to the outpatient service, and submitted a statutory notification to us of this change. We have placed restrictions on the provider's registration that state this service cannot re-open without our agreement which would be dependent on the concerns raised on our inspection being addressed.

Information about The Raphael Medical Centre

The Raphael Medical Centre (RMC) is a location provided and managed by Raphael Medical Centre Limited, an organisation which also provides social care services for people with acquired brain injuries.

The RMC is registered with the Care Quality Commission to provide the following regulated activities:Treatment of disease, disorder or injury, diagnostic and screening procedures and assessment or medical treatment for persons detained under the Mental Health Act 1983.

There are facilities to accommodate 47 patients in total. There is space for 33 in two wards in the main building, nine patients in Tobias House, which is a designated as an area for the treatment of prolonged disorders of consciousness. There is capacity to treat up to eight patients in the special care unit (SCU) for neuro behavioural rehabilitation and this unit also accommodates patients admitted under the Mental Health Act.

Referrals are accepted from across the south-east of England. The majority of referrals are received from Clinical Commissioning Groups (CCG's). The RMC also accepts private patients funded by patients themselves or insurance companies.

The RMC offers outpatients services in two treatment rooms and one consulting room in a courtyard building.

The outpatient services specialise in hyperthermia treatment and intravenous mistletoe therapy for adults with cancer. Patients are referred by their treating doctor or by self-referral and pay for their treatment.

The RMC provides a service for people over the age of 18 years and does not treat children or young people.

The service employs about 105 whole time equivalent clinical staff including doctors, nurses, therapists and care assistants.

The service does not currently provide imaging or pharmacy services. There is a Controlled Drugs Accountable Officer at the location.

The hospital received 89 referrals for admission between July 2014 and June 2015. Sixty one of these had complex disabilities. All patients are referred by and subsequently funded by their relevant CCG.

Out-patient appointments are usually available two days each week. Between August 2015 and November 2015 there were 205 scheduled appointments; 22 of these appointments were cancelled, and a further 17 were not attended.

Two days following our inspection visit, the hospital contacted the CQC and informed us that a decision had been made by the executive board of directors to close the outpatients services with immediate effect. The

Summary of this inspection

registered manager reviewed the organisation's statement of purpose and removed reference to the outpatient service, and submitted a statutory notification to us of this change.

What people who use the service say

Patients and their relatives told us staff were kind and compassionate, and that their privacy was respected and dignity maintained. Relatives expressed confidence in the team and reported they felt their relatives were well cared for and made good progress.

We provided the hospital with feedback boxes that enabled patients and their relatives to complete anonymous comment cards about the hospital. Positive comments were around good care received, amount of therapy received and progress made by patients. Negative comments were around poor hygiene, lack of stimulation and no personalisation of rooms.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found safety was not a sufficient priority. We identified concerns in relation to the environment, arrangements to identify and support patients whose condition is deteriorating, shortfalls in infection control procedures, issues with the supply and administration of unlicensed medicines and learning from incidents. However, staff were committed to a culture of openness and transparency and staffing levels met published guidance and were sufficient to meet patients' needs.

Are services effective?

Overall, we found that care followed national guidance but there was no systematic gathering of data about outcomes of treatment, for treatment or benchmarking of the effectiveness of care. Staff were appropriately qualified and registered to carry out their jobs, but consultants working at the hospital did not have practising privileges agreements. We found that the service was compliant with requirements of the Mental Capacity Act 2005, and the Deprivation of Liberties safeguard (DoLS).

Are services caring?

Patients and their relatives reported receiving care that was compassionate and respected their privacy and maintained their dignity and we saw care being delivered in this manner. Overall, staff provided adequate emotional support to patients although this was not clearly documented.

Are services responsive?

We found there were arrangements to ensure patients could access a service that was appropriate to their needs in a timely way. Complaints were taken seriously and investigated but there were insufficient arrangements to ensure there was learning from complaints.

Are services well-led?

The governance arrangements did not adequately monitor performance and risks or provide appropriate assurance to the board. Staff told us they felt supported by their managers but we encountered a "control and command" model of leadership. We found that staff supported the anthroposophical ethos of the hospital. The hospital had an active research portfolio with a national and international profile.

Detailed findings from this inspection

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Raphael Medical Centre (RMC) offers outpatients services in two treatment rooms and one consulting room in a courtyard building. The outpatient services specialise in hyperthermia treatment and intravenous mistletoe therapy for adults with cancer. Patients are referred by their treating doctor or by self-referral. Treatment is based on a spiritual philosophy and approach, known as anthroposophical medicine. At RMC, this approach is mainly used in conjunction with conventional therapies.

The outpatients services are staffed by a medical consultant, a registered nurse, and a service manager, with additional support from a resident doctor, and administrative staff, who are located in the main building at RMC. Appointments are usually available two days each week, depending on staff availability. Between August 2015 and November 2015 there were 205 scheduled appointments; 22 of these appointments were cancelled, and a further 17 were not attended.

Diagnostic imaging services are not provided at RMC and therefore were not assessed as part of this inspection.

During our announced on-site inspection no clinics were scheduled. Therefore we obtained feedback from patients over the telephone. We visited all parts of the outpatients department, considered the environment and equipment, spoke with eight patients by telephone, and spoke with seven members of staff who worked in the department and the executive management team. We looked at records, including nine patient care records. Before and during our announced inspection we also reviewed performance information about the service.

Summary of findings

Following our announced inspection we were informed by the registered manager that a decision had been made by the executive board of directors to close the outpatients services with immediate effect. The registered manager reviewed the organisation's statement of purpose and removed reference to the outpatient service, and submitted a statutory notification to us of this change. We carried out an unannounced inspection and saw the unit was closed. We have placed restrictions on the provider's registration that state this service cannot re-open without our agreement which would be dependent on the concerns raised on our inspection being addressed.

The safety, effectiveness, responsiveness and leadership aspects of the outpatient service were inadequate. Caring required improvement.

Safety was not a sufficient priority. There were inadequate systems in place for staff to assess, monitor or manage the risks to people who used the services. Opportunities to prevent or minimise harm were missed. There were inadequate arrangements to ensure people's safety in the event of a fire. National specifications for infection prevention and control and cleanliness, and the proper and safe use of medicines were not adhered to. Staff did not report safety incidents in the approved manner, and there was inconsistent learning from incidents. Staff understanding of what to do in an emergency could be improved.

There was insufficient assurance to demonstrate people received effective care based on current evidence-based guidance, standards and practice. There was no monitoring of people's outcomes of care and treatment.

Outpatients and diagnostic imaging

Staff provided care in isolation and did not seek support or input from other relevant teams and services. Information about people's care was not appropriately shared and systems to manage and share care records were uncoordinated.

The majority of patients we spoke with gave positive feedback about the way staff treated them. However, staff did not see privacy as a priority. People's emotional and social needs were not always viewed as important or reflected in their care and treatment.

Services were not always responsive to the needs of patients. There was no regular pattern to the schedule of appointments, with variations based on staff availability rather than patient choice.

The governance arrangements and their purpose were unclear with ineffective arrangements for the systematic provision of assurance to the board that risks were being adequately assessed or managed. There was an absence of processes and protocols used to monitor outcomes of care, performance or make decisions. There was minimal engagement with people who used the service, staff or the public. We saw no evidence of innovative practice or service development.

Are outpatients and diagnostic imaging services safe?

We rated safety of the outpatient services as inadequate because the systems in place to highlight risks, incidents and near misses were not adhered to. We observed environmental risks, such as infection risks and fire hazards that were not identified or acted upon. None of the patient records we looked at included assessment of clinical risks such as pressure ulcer development, falls or risk of deteriorating health and well-being.

Staff told us they did not routinely report incidents on the required incident report form, some of which could potentially cause harm.

There were no apparent means of fire detection, of raising the alarm in the event of a fire or of identifying fire exits. The spread of fire would not be contained as none of the doors we saw had fire protection, known as intumescent strips, to stop the spread of fire and smoke.

Infection control practices did not comply with the department of health's code of practice for infection control, Health Building Note 00-09 Infection Control in the built environment (HBM 00.09) or other national cleaning specifications. There was no evidence of a preventative maintenance or cleaning programme in place, or any infection prevention and control audits. Wall surfaces, soft furnishings and floor surfaces were not easily cleanable and were inappropriate for a clinical environment.

Arrangements designed to enable the safe supply and administrations of medicines were not effective. The medicines management policy was past its review date meaning that there was a risk that practice could be out of date or ineffective. Not all staff were aware of the policy, or acted in accordance with its requirements. Staff were not accessing supplies of medicines in a consistent way.

Staff we spoke with knew how to access safeguarding policies and procedures and demonstrated a good understanding of the processes involved for raising a safeguarding alert.

Incidents

- There were arrangements in place to report safety incidents using a paper based system. Staff told us there had not been any reported safety incidents or near

misses in the last year. However, when we asked for documentary evidence, staff told us they did not use the approved reporting system and would record incidents in individual patient notes. This meant that staff were not taking individual responsibility for recording incidents, that safety performance was not measured over time, and that the review of incidents and cascade of learning and required actions was not always timely.

- Managers confirmed there were no reported never events in the outpatient services in 2015. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- There was no evidence to show that patient safety incidents were investigated or that learning from patient safety incidents within or outside of the organisation were shared. Staff confirmed this to be the case.

Cleanliness, infection control and hygiene

- Infection control practices did not generally comply with the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and associated guidance. For example, there was no evidence that infection prevention and control audits to monitor compliance with handwashing, or the use of personal protective equipment (PPE) and isolation were undertaken in the outpatient service.
- Cleaning schedules and checklists were not available. Staff could not confirm when cleaning took place, or how soft furnishings such as patient chairs were cleaned between use by different patients.
- Carpet was used as a floor covering throughout the facility, including in treatment rooms and bathrooms. Carpet has a high probability of cross contamination. We asked for evidence of specific risk assessment of carpeted areas and were told that none had been undertaken. Staff were unable to confirm when the carpets had last been cleaned.
- We saw PPE and hand sanitisers were available, but neither were stored in wall mounted dispensers as required by Health Building Note 00-09 This increased the risk of cross contamination from contact with the dispensing mechanism.
- There was a clean utility room adjacent to the treatment room where medicines and clean and sterile supplies were held, and hand-hygiene facilities provided. However, there was no segregation of clinical and non-clinical waste. This increased the risk of cross contamination.
- Bedpans and urinals were reusable, and were stored on the bathroom floor. There was no designated space or facility for holding, reprocessing or disposing of bedpans, urinals or vomit bowls. There was no bedpan washer-disinfector. Staff told us they would clean these items in the bathroom, but were unable to define the specific cleaning and disinfection processes used.

Environment and equipment

- First aid equipment, oxygen, and emergency medicines were available in case of an emergency and checked on the days the outpatients facilities were open, to ensure it was available and fit to use. Not all staff working in the unit were trained in its use.
- The first aid equipment had an expiry date of 2010. This meant that basic health and safety checks had been overlooked. We brought this to the immediate attention of staff and asked that corrective action was taken. However, when we checked on this on the second day of our inspection, no action had been taken.
- There was no apparent means of raising the alarm in the event of a fire. The spread of fire would not be contained as none of the doors we saw had fire protection to stop the spread of fire and smoke.
- There were no marked fire exits and no directional signs commonly known as "green running man" signs to direct patients and staff to a fire exit.
- There was a large heated piece of equipment which was used to deliver the hyperthermia treatment, which would heighten the risk of fire. Staff could not produce a risk assessment and could not tell us if one had been carried out or acted upon.
- We did not see any accessible moving and handling equipment in the outpatient department.
- The treatment rooms and bathroom were cramped and were not in good decorative order. Wall surfaces, flooring, and furniture were not easily cleanable which could lead to the rough surfaces harbouring bacteria.

Outpatients and diagnostic imaging

- There were no call bells for patients to use. Staff told us that patients were never left unattended, and in the case of an emergency would summon assistance from colleagues in the main building by telephone. Staff who worked in the main building confirmed this to be the case.
- Not all electrical equipment was regularly serviced, or tested by internal or external maintenance staff. In particular, office equipment in the doctor's consulting room and administration office. Blood pressure machines and weighing scales were not recently calibrated and there were no systems to ensure this was done.

Medicines

- Systems for the management of medicines were set out in: Policy for the Management of Medicines, RMC, 2014. Not all staff working in the department were aware of the policy, or acted in accordance with its requirements, for example the prescriber's signature was not identifiable in all cases. The policy was past its review date which meant that there was a risk that practice could be out of date or ineffective.
- Arrangements for the pharmacy services were unclear. There was no service level agreement for contracted services. Staff told us there was an arrangement with an off-site pharmacy supplier and that they had no direct access to a clinical pharmacist. There had been no formal review of the pharmacy services for outpatients at RMC since the centre opened in 2010.
- Mistletoe is an unlicensed medicinal product in the UK. The MHRA guidance specifies that any unlicensed medicinal product may be imported and supplied to the order of a prescriber to meet the clinical needs of an individual patient, on a named basis. We saw that not all medicines were supplied on a named patient basis. Records were not kept for all unlicensed medicines, such as mistletoe and some herbal remedies.
- Medicines stocks for use with patients at RMC were obtained from a German supplier via a pharmacy in the UK, who is a wholesale dealer's licence holder. The importer of any unlicensed medicinal products into the UK must hold a wholesale dealer's licence if the product is to be imported from an EEA member state. However staff told us there had been occasions when medicines supplies were not available through this route and therefore alternative arrangements took place. However there was no record of this having been reported as an incident, identified as a risk or what processes took place.
- The entire stock of mistletoe used in the outpatient services was presented in packaging that was labelled in German, and contained product information leaflets in German. This meant that patients and staff involved in administration did not have access to easily understandable literature.
- Medicines were generally stored safely and in accordance with the RMC policy. The minimum and maximum temperature of fridges used to store medicines that required refrigeration were monitored to ensure that medicines were stored at the correct temperature. However, we found four ampoules of mistletoe that were not stored in their original packaging which was not in line with this policy. We also found a patient's own medicines stored in the refrigerator.
- Prescriptions for licensed and unlicensed medicines were administered on the written instruction of the consultant. However, all of the patient records we looked at showed that the prescribing doctor's full signature was not included and was not identifiable in all cases.
- Staff referred to product manufacturer information for medicines and medical devices (equipment); however there was no publication or review date for the product manufacturer information. We saw out of date information in the mistletoe therapy booklet, advising people to obtain support and counselling from NHS Direct, an organisation that ceased to exist in February 2014.
- Staff told us the standard operating procedure for mistletoe therapy had been approved by the RMC clinical governance committee. We asked for evidence of this, and none was available.
- There were systems in place to allow patients to self-administer their medicines, including injections, at home. Where this happened, there was no record of any assessment of the patient's suitability, agreement to self-administer, or the instructions that had been provided. Staff confirmed this did not take place.

Outpatients and diagnostic imaging

- Emergency medicines and oxygen were clearly labelled and regularly checked to ensure they were in sufficient supply, were within date, and were ready to use. All of the medicines we looked at were in date.
- There were no signs to indicate that oxygen, a flammable gas, were stored in the location. This meant people may not be aware of the associated risks.

Records

- We looked at the medical records of nine patients. All patient records were maintained in a paper format and were legible, dated and signed. Records were stored securely in a locked cabinet and were inaccessible by patients and visitors.
- People's individual care records were not always written and managed in a way that kept people safe. There were no systems in the records to alert another health care professional to a patient's needs or allergies. This meant that a significant medical problem could go unnoticed. We saw no evidence in patients' records that the medical consultant or nursing staff had produced any written correspondence for the patient's referring practitioner or other health professionals.
- There were no personalised nursing care plans in place. Records we looked at did not show evidence of assessing or managing the patients' venous access. Staff confirmed this did not happen.

Safeguarding

- Staff knew how to access safeguarding policies and procedures and demonstrated a good understanding of the processes involved for raising a safeguarding alert.
- All staff in the outpatient services had completed safeguarding training.
- There was no information available in the waiting areas for patients on how to raise safeguarding concerns.

Mandatory training

- Mandatory training provided by RMC for staff working in the department covered a range of topics including moving and handling, fire safety, hand hygiene, safeguarding adults, equality and diversity and life support.
- Mandatory training including fire safety training for staff was undertaken by e-learning, and was not provided for all groups of staff. This did not take into account significant findings from risk assessments, or changes in working practices. Staff were not trained in job-specific fire evacuation techniques.
- Not all staff had completed the required mandatory training, for example a consultant had not completed life support training. Where there was such non-compliance with completion of mandatory training there was no evidence that a risk assessment was carried out, or that managers took corrective action.

Assessing and responding to patient risk

- All staff we spoke with were able to describe the actions required when a patient collapsed and how to summons emergency assistance. However, not all clinical staff were clear of their responsibilities.
- There were no emergency call bells in place. Staff told us that patients were never left unattended and that nursing staff were always available.
- None of the patient records we looked at included clinical risk assessments such as pressure ulcer risk assessments, falls assessments, or risk of deteriorating health and well-being. Staff we spoke with confirmed these risk assessments were not documented.
- There were no clearly defined processes to monitor the patients' condition during hyperthermia treatment. However staff told us they would record people's vital signs. Records we looked at demonstrated that people's vital signs were monitored and recorded throughout their treatment.
- In addition to the medical consultant and nursing staff, a resident medical doctor was available from the main site at RMC at all times if a patient required medical support. Staff told us that response from the on call doctor was always immediate, and patients would be transferred to an NHS hospital if their clinical condition required it.

Nursing staffing

- When patients attended the clinic there would be at least one member of nursing staff working with the medical consultant. The nurses worked in the inpatient

Outpatients and diagnostic imaging

service at RMC on days when the outpatient service was not open. This allowed them to keep up to date with other aspects of nursing practice, and participate in learning and development.

- Agency nursing staff were never used. Nursing staff told us that no absence cover was provided when they, or the consultant, were on leave, and that the service would be closed on those occasions.

Medical staffing

- All of the patients were under the care of a medical consultant for their treatment. The consultant provided a 24 hour "on call" telephone advice service when they were not on-site.
- RMC policy required that the doctor would administer intravenous mistletoe; however we saw evidence in patient care records that this was not always the case, as nurses would do so in their absence.
- A medical consultant or other clinician cannot provide care and treatment to patients attending an independent health care facility without being granted practising privileges. We asked to see evidence of such contractual arrangements in place, and none was available. We were told by the management team that the consultant did not have a formal practising privileges agreement although they were working in that capacity.

Major incident awareness and training

- An up to date business continuity plan that had been approved by the RMC Clinical Governance Committee was reviewed annually. However, staff we spoke with were not aware of the policy and could not recall any training in this area.

Are outpatients and diagnostic imaging services effective?

Staff who worked in the outpatients services demonstrated limited awareness of the best practice guidance they should be following. We saw unlicensed medicines or practices in place that were not supported by external guidance.

Although RMC had an audit plan in place, staff told us that the outpatient service had not participated in any local or national audit activity.

There were some arrangements in place to ensure suitably qualified staff completed relevant learning and development. Staff acknowledged that there was room for improvement in this area, as they had not consistently participated in learning opportunities, including mandatory training.

Systems to manage and share care records were uncoordinated.

Evidence-based care and treatment

- Staff showed very limited awareness of evidence based external references or policies based on national standards such as guidelines from the National Institute for Health and Care Excellence or the Royal Colleges, and were unable to provide evidence of their application to practice.
- There were no formal links with other cancer services or a palliative care team.
- Staff told us they referred to paper copies of the British National Formulary (BNF) as an authoritative and practical source of information on the selection and use of medicines. We saw all three available copies of the BNF supplied were out of date as were the children's' formulary. This meant there was a risk of staff referring to unreliable information.

Nutrition and hydration

- Staff told us that patients would be offered drinks and snacks served from a small kitchen or the main RMC kitchen accordingly. The small kitchen area was cramped and cluttered with unwashed crockery, glasses and cutlery. There was no indication of when it was last cleaned and staff were unable to confirm when this had happened.
- There was no record of peoples' nutritional likes and dislikes or any special dietary needs in their records, or a record of their weight. Staff confirmed patients' weights were not monitored. There was no records of nutritional assessments being completed.

Pain relief

Outpatients and diagnostic imaging

- Pain relief was not specifically managed by the outpatient service, however we saw in patients' records that pain relief was prescribed, supplied and administered on an as necessary basis. Staff we spoke with demonstrated limited awareness of up to date knowledge of pain management techniques.

Patient outcomes

- There were no formal measures in place to gather patient feedback.
- There was no participation and performance in local or national audit. We saw an audit schedule that showed clinical audits were planned on a quarterly basis for a range of clinical practice, however staff confirmed none of these plans had been implemented.
- Nursing staff told us there was a protocol for doctors to follow when prescribing antibiotics. However, there had been no audits of the use

Competent staff

- A medical consultant or other clinician cannot provide care and treatment to patients attending an independent health care facility without being granted practising privileges. We asked to see evidence of such contractual arrangements in place, and none was available.
- Statutory professional registration checks (for the nurse and doctor) were undertaken by the human resource director, and we saw records that confirmed this.
- We saw staff records which showed the medical consultant had completed the revalidation processes required by the GMC confirming their fitness to practise.
- All the staff we spoke with told us they had recently undertaken an annual appraisal. Records we looked at confirmed this. Managers told us there were no systems in place to identify or escalate trends emerging from appraisals.
- The medical consultant told us they were assured of the competence of nursing staff through observation of practice; however assessment of competence and the outcomes of the assessment were not always documented and therefore not available for us to consider.

Multidisciplinary working

- There was a formal service level agreement to enable staff to work with an external pathology service. However there were no formal arrangements for other external specialty services such as diagnostic imaging, pharmacy or therapies or for transfer of patients to the NHS.
- We found that medical and nursing staff worked collaboratively.
- No allied health professionals were assigned to the service.

Seven-day services

- The service did not provide a seven day service. Patients told us they were able to contact the doctor and RMC for telephone advice out of hours, and were satisfied with the response and information provided.

Access to information

- There was no integrated care record which meant that different groups of professionals were not always accessing information in a timely way. This meant there was a risk that patient safety could be compromised by health care professionals.
- Staff were unclear of the arrangements in place for the provision of translation and interpreting services for people for whom English was not their first language.
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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were processes in place to discuss the risks and benefits associated with treatment. Patients we spoke with told us they had been encouraged to take part in decision making and gave their consent.
- All the records we looked at showed that patients had consented to the treatment they received, and the forms were clear to understand.

Are outpatients and diagnostic imaging services caring?

People we spoke with were generally positive about the way they had been treated and told us that the staff were kind and treated them with respect. However, patients' privacy was not always achieved, particularly auditory privacy, due to the cramped environment.

Outpatients and diagnostic imaging

People's emotional and social needs were not always viewed as important or reflected in their care and treatment.

Compassionate care

- Patients we spoke with mainly described their experience as positive and told us they were treated in a caring and supportive way by all staff.
- Patients said there was limited privacy provided by mobile screens, and on occasions felt this had been compromised. Although there were screens available to allow patients' privacy, these did not provide auditory privacy. One patient told us the screens were not routinely used during their treatment. Staff told us they would use screens on a discretionary basis.
- There were no formal chaperoning arrangements in place.

Understanding and involvement of patients and those close to them

- There was very limited information available for patients and we saw no evidence in records we looked at that treatment plans were discussed in relation to duration, likely outcomes or success of treatment.
- We saw out of date information in the mistletoe therapy booklet, advising people to obtain and support counselling from NHS Direct, an organisation that ceased to exist in February 2014.
- Patients we spoke with were largely unsure of their treatment plan.

Emotional support

- Staff we spoke with told us there were no formal arrangements in place to provide emotional support to patients or those close to them, and told us they had not received specific training in this area. Patient records we looked at showed limited evidence of emotional support provided, and no evidence of referral to other specialist services.
- Staff we spoke with were unable to give us examples of how people's emotional, social and spiritual needs had been assessed and interventions to meet these incorporated into their care and treatment plans.

Are outpatients and diagnostic imaging services responsive?

There were limited planned appointment schedules on two days a week with appointments scheduled according to staff availability. Between August and November 2015 there were 205 scheduled appointments within the outpatient services, 22 appointments were cancelled, and a further 17 patients did not attend. We were told that the average waiting time for an initial appointment was around seven weeks at the time of our inspection. However, there was no formal monitoring of waiting times, cancelled appointments or evidence that services responded to peoples' needs in a flexible way.

People were not given written information about treatment other than product information.

Patients told us they were disappointed with the lack of waiting areas, and facilities for relatives accompanying them to their appointment. Bathroom facilities were shared by staff and patients, and were limited. Information about people's care was not appropriately shared with other health care professionals.

Service planning and delivery to meet the needs of local people

- Staff told us the demand for outpatient services was generally met; however there was no formal monitoring of the service provided to verify this.
- When booking appointments, the doctor advised on their availability, and would either directly book appointments or they would be made by a member of the administrative staff. The number and reasons for cancelled appointments and clinics that overran was not being monitored.
- There was no formal monitoring of the level of enquiries, source of enquiries, conversations or tasks.
- The pathology service was provided by an external agency with a service level agreement in place.

Access and flow

- Waiting times for outpatient appointments were not monitored. Staff told us there was currently a seven to eight week wait for an initial appointment.

Outpatients and diagnostic imaging

- The majority of patients told us they had not generally been kept waiting for their consultation once they had arrived in the department. If this had happened they were kept informed by reception staff.

Meeting people's individual needs

- Patients were not generally offered a choice of appointment time, as this depended on staff availability. One patient told us they had discharged themselves from the clinic because the appointment times were unpredictable and did not meet their needs.
- The amount of time between the initial consultation and treatment was not being monitored. Patients we spoke with were largely unsure of their individual schedule of appointments.
- Staff were not aware of any formal arrangements for dealing with patients with complex needs including learning disabilities, dementia, and access to services. However, we saw no evidence that these services had been required.
- There were two toilets available for both staff and patients to share, and no easy access for people with disabilities. Patients told us this meant they had to use bedpans or urinals on occasions which had the potential to compromise their dignity.
- There was no waiting space or seating in the courtyard building. This meant that people had to wait in the main building clinic reception area. One patient told us they found this difficult because of their limited mobility.
- There was no seating or waiting area for patients or those accompanying them to appointments. One patient told us that whilst they were having treatment their accompanying relative had to wait for over three hours in the main reception area at RMC, without refreshment facilities.
- Patients also told us financial transactions were carried out in the public waiting area, with little privacy.

Learning from complaints and concerns

- Staff in the outpatients' service did not handle complaints at a local level, but would refer to the relevant service director. Staff told us there were no unresolved complaints at the time of our visit.
- Staff did not maintain log of complaints for monitoring, learning or audit purposes. We asked for a summary of the complaints which we were told was not available.
- There were no regular updates for staff about complaints management within RMC. This meant that lessons from complaints were not routinely shared to improve the quality of care across the services.
- We saw no available information for patients on how to make a complaint or raise concerns. Patients we spoke with could not recall being provided with such information, however they all knew the name of the RMC chief executive and told us they would feel confident raising any concerns directly with them.

Are outpatients and diagnostic imaging services well-led?

We had concerns regarding the leadership in the outpatient service as the delivery of high quality care was not assured by the leadership, governance or culture in place.

The governance arrangements and their purpose were unclear. There was no effective system for identifying, capturing and managing risks at departmental level. Significant issues that threatened the delivery of safe and effective care were not identified and therefore adequate action to manage them was not taken.

Where there was non-compliance with local policies and procedures this was not being challenged or questioned. For example: environmental risk assessment, fire safety, cancelled clinics, medicines management and infection prevention and control.

There was no evidence of innovation or service development. There was minimal evidence of learning or reflective practice.

Vision and strategy

- Managers and staff were unable to describe the vision for the service and told us there was no specific documented strategy for developing the outpatient's service.

Governance, risk management and quality measurement

- The medical consultant was the clinical governance lead for the service. There was no clinical risk register

and no formal link between them and the medical advisory committee or other governance forums within RMC. This meant dissemination of information to and from the RMC board was limited.

- Some organisational non-clinical risks were recorded in an 'identified threats register' maintained by RMC, which included anything that could interrupt the service. There were no specific risks listed for the outpatient services, or documented responsibilities for action or action taken.
- Staff told us they were unsure of the governance arrangements in place to ensure the quality, safety, and effectiveness of medicines. There was a lack of clear policy on the use of unlicensed medicines, and a lack of risk assessment applied to consider the specification of unlicensed medicines or treatments to be used.
- Staff told us there was no formal cycle of policy review in outpatients. Some policies we looked at were not dated and had no review date. Other policies we saw were past their review date. We were told that policies were ratified by the clinical governance committee. Minutes of meetings we looked at did not confirm this happened, for example administration of intravenous mistletoe therapy policy.
- Where there was non-compliance with local policies and procedures this was not being challenged or questioned. For example where staff were not following medicines management, mandatory training and infection prevention and control procedures, and audit of these practices.
- There was no evidence that infection prevention and control audits to monitor compliance with handwashing, or the use of personal protective equipment (PPE) and isolation were undertaken in the outpatient service. There was also no evidence to demonstrate that ongoing assessment of the standards of cleanliness was in place.

Leadership / culture of service

- Staff told us they felt remote from the rest of the RMC and did not attend regular departmental meetings. However, staff felt the executive team were visible and approachable.

Public and staff engagement

- Staff told us that staff meetings were informal and not generally documented.
- Outpatients staff told us they did not feel involved in the business strategy.
- There was an absence of systems to ensure public and staff engagement in the outpatients' department. Staff we spoke with could not describe any methods by which they formally obtained and analysed feedback from patients and their relatives, or how they influenced the delivery and development of the service.

Innovation, improvement and sustainability

- The outpatient service did not work with other departments at RMC to compare practices and data, or establish peer groups to assess performance.
- There was no engagement with professional forums of other similar services, or participation in relevant research activity. Staff could not give us any examples of research activity or innovation they had participated in.
- Staff told us their continuing professional development was limited, as the outpatients services only operated two days a week which meant there was limited opportunity to attend networks or external learning events.

Long term conditions

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Long term conditions services at the Raphael Medical Centre focuses on the care, treatment and rehabilitation of people with acquired brain injuries. There are two inpatient wards in the main building which could accommodate a total of 33 patients. The courtyard contained the specialist care unit (SCU) which accommodates eight patients for neuro-behavioural rehabilitation and also accommodates patients admitted under the Mental Health Act. Nine patients are accommodated in the ground floor of Tobias House which cared for patients in prolonged disorders of consciousness including those requiring ventilation.

At the time of inspection there were 30 patients in the main house, eight patients in SCU and nine patients in Tobias House. The hospital received 89 referrals for admission between July 2014 and June 2015. Sixty one of these had complex disabilities. Patients are referred by and subsequently admitted by their relevant Clinical Commissioning Group (CCG) although the hospital accepts private patients.

To help us understand and judge the quality of care for patients with long term neurological conditions at RMC we used a variety of methods to gather evidence. We spoke with managers, medical staff, nursing staff, allied health professionals and support workers. We also spoke with 12 patients and 11 of their relatives. We observed the care and environment, and looked at 14 patient records, including patient care records. We looked at a range of documents, including audit results, action plans, policies and management information reports.

We reviewed information received from members of the public who contacted us independently to tell us about their experiences. We analysed patient surveys and other performance information held about the hospital.

Summary of findings

Overall we had concerns about some aspects of patient safety in the long term conditions service at RMC. This is because we identified concerns in relation to the environment, arrangements to identify and support patients whose condition is deteriorating and shortfalls in infection control procedures. We found that there were good systems in place to report and investigate safety incidents but staff did not receive feedback. Additionally we saw no evidence of lessons learned by incidents that had been reported.

We found that treatment generally followed current national guidance. The hospital had policies and guidelines in place for most areas of the hospital. However, although the hospital acknowledged the national guidelines the hospitals policies did not fully reflect their content.

Patients were cared for by a multidisciplinary team working in a cohesive way and generally had access to services seven days a week. We found that there were arrangements to ensure that staff were competent and confident to look after patients. However we observed that there were some therapists who were not registered although they were using a protected title. Also the hospital employed four doctors working under practising privileges but was unable to provide a formal agreement that set out the rules and conditions of their employment.

Patients' dietary and nutritional needs were met and were supported appropriately when problems occurred. Consent was obtained and recorded in patients notes in

Long term conditions

line with relevant guidance and legislation and where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligation under the Mental Health Act.

We judged the caring aspects of long term conditions as good. Patients and their relatives were positive about their experience of the care and the kindness afforded to them. We observed compassionate care that promoted patients privacy and dignity. Patients and their relatives were involved in their care and treatment and were given the right amount of information to support their decision making.

We judged that the responsiveness of long term conditions as requires improvement. Discharge planning was started upon a patient's admission and the service encouraged and supported social reintegration from the point of admission. However, the hospital did not acknowledge end of life care, advance care planning, and the recognition for emotional support and spiritual needs of the patient.

We rated long term conditions as required improvement for well-led. The hospital supported learning and innovation and promoted an open and fair culture. They had a governance structure but did not monitor performance and risk issues. The management culture was directive and there was limited delegation of responsibilities.

Are long term conditions safe?

Staff we spoke to had a clear understanding of their role in reporting incidents. However, when incidents occurred, investigations were not sufficiently robust and learning was not widely disseminated. Staff reporting incidents did not always receive feedback.

There was only limited measurement or monitoring of safety performance and some operating procedures had not been audited or updated. For example, water safety testing or monitoring of cleaning standards.

The hospital did not meet current Department of Health (DOH) guidance regarding cleanliness, infection control and hygiene. For example, we did not observe equipment being cleaned between patients.

We found that RMC did not comply with the DOH, Health Technical Memorandum (HTMs) guidance for shower heads, carpets**,** wall surfaces, provision of hand wash basins, soft furnishings, waste and water safety management and fire safety. The hospital did not have an operational plan for cleaning or a robust system on which the cleaning was based.

The hospital had a risk management policy for business continuity planning and a 'human side of business and technical plan' However, these plans were not robust as they did not provide guidance for staff in the event of a disaster.

All patients were under the care of a consultant for their relevant conditions. Nursing, therapy and medical staffing levels adhered to relevant guidelines such as the British Society of Rehabilitation Medicine (BSRM) and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.

We saw that all staff received regular mandatory training including safeguarding.

Incidents

- The hospital reported two incidents of patient death between July 2014 and June 2015. Both of these were patients who were subject to an authorisation to deprive them of their liberty from a supervisory body or the Court of Protection.

Long term conditions

- There were no 'never events' or serious incidents reported by the hospital between the period July 2014 and June 2015. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- The hospital had an incident reporting policy written in 2015, which was authored by the director of nursing and approved by the clinical governance committee (CGC). The policy contained the role of the hospital and its employees in the event of an incident. It included examples of an incident reporting form and a flowchart for the reporting of incidents. In the event of an incident all employees were to report to their line manager and record all facts on the incident report form which was passed to the patient safety team. The team, led by the director of nursing, participated in the appropriate investigation to ensure that learning and improvement was identified and disseminated across the hospital. The team was also required to provide assurance to the governance committee that the reporting arrangements were robust and appropriate.
- We found instances where incidents had not been reported. For example, in relation to out of range fridge temperatures, staff told us they had highlighted this to management but were unable to tell us if an incident form had been completed. Staff also told us they had identified a number of labelling errors on medications received from the pharmacy. We were told that this had been reported to management who had contacted the pharmacy but there had not been a change to the service provided. Staff were not able to provide evidence that this had been reported as a formal incident.
- We asked the hospital to provide data of reported incidents. We were provided with data of 25 incidents between 01 September 2015 and 30 October 2015. One related to security/ damage to property, two to equipment, three to personal accident, one clinical care, nine violence/abuse/harassment, six were graded as 'other' and three had no category. Eighteen of the incidents occurred in the Special Care Unit (SCU). There was no catastrophic incidents, two major, 10 moderate, four minor, one insignificant and eight were ungraded.
- The hospitals incident reporting policy stated that any 'lessons learned' should be recorded but also noted that not every incident would result in new learning. Of the 25 incidents provided by the hospital only one incident, a major incident, had 'lessons learned' reported. This related to a patient who had fallen while outside and the 'lessons learned' recorded was for the patient to be accompanied when outside. The other major incident related to a patient who had complained that they had been physically assaulted and this was reported to an outside organisation. We also saw 12 incident forms in patient notes and the 'lessons learned' section was not completed on any of these forms.
- The policy also stated that it should ensure that appropriate feedback was provided to the person who reported the incident. Staff said in the nursing and support staff focus groups that they had a clear understanding of their role in reporting safety incidents. They told us they knew how to complete an incident report and this went directly to the director of nursing.
- Therapy staff told us that they knew how to report incidents and were clear about what to report and when. However, they told us that they had not consistently received feedback following incidents reported. We saw minutes of staff meetings for July, September, October and November 2015. Reported incidents were not discussed at these meetings.
- The incident policy stated that incidents should be reviewed as part of their internal governance arrangements so that they can work together to consider how to improve systems and processes. The hospital's Medical Advisory Committee (MAC) met every three months and they reviewed any mortality and morbidity data. The hospital told us that their aim was to learn from these events and determine that processes and procedures were fit for purpose. We saw in the MAC minutes for November 2015 the committee discussed a death and the procedure to be followed. However, the discussion was superficial and did not identify any learning points.

- The hospital had a whistleblowing policy which was part 9, section A of the employee handbook 2015. We asked staff in all three focus groups if they were aware of the policy and the procedure involved. They confirmed they did.
- We asked staff about Duty of Candour. They told us that they were open and honest and actioned any concern before it could escalate to a bigger problem. They explained that the key was effective communication and being empathetic with patients and their relatives.

Cleanliness, infection control and hygiene

- The hospital had an infection control procedure written in 2014 which provided clear guidelines and protocols for both individual patients and the environment to reduce the risk of infections. Subjects covered included antibiotic usage, clinical and nursing practices. Operational policies included laundry and the cleaning of equipment.
- The procedure stated it had an infection control team who had the primary responsibility for all aspects of surveillance, prevention and control of infection within the hospital and reported to the director. The infection control team had the responsibility to implement an annual programme and policies and to make medical and nursing decisions on a 24 hour basis about the prevention and control of infection. They were to provide advice to all grades of staff on the management of infected patients and other infection control problems.
- Additionally the procedure stated that audits should be performed and other mechanisms established to evaluate the effectiveness and the extent of the implementation of policies and procedures. However, we found no evidence of an infection control team or who was involved.
- The hospital told us that they had an infection and prevention control (IPC) lead and this was confirmed by staff we asked. However, the hospital did not have a separate IPC committee and did not report to clinical governance committee as a formal process. Ward managers undertook IPC audits and presented to the clinical governance committee as audits rather than a report.
- We saw clinical staff and support workers complying with the hospital's policies and guidance on the use of personal protective equipment (PPE). We observed staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients. We saw that on entrances to buildings and clinical areas there was hand gel available and we observed staff and visitors use them.
- Before inspection we requested data regarding hospital acquired infections. For the period July 2014 to June 2015 there were no cases reported of Clostridium-difficile (C.diff) and methicillin-susceptible staphyloccus aureus (MSSA) and seven cases of methicillin-resistant staphylococcus aureus (MRSA) colonisation but no blood-stream infections. The hospital told us that all of the MRSA infections were acquired before patients were transferred to RMC after admission in a NHS hospital. We were told that all patients were screened for MRSA on initial admission to RMC and re-admission after hospital stays. We saw in patient's medical notes documentation regarding these assessments. We were told that this meant that colonisations were detected straight away and treated with 100% success rate.
- For the period July 2014 to June 2015 the hospital reported 33 cases of urinary tract infections (UTIs). The hospital told us that this figure was high due to the majority of patients suffering from incontinence. Pseudomonas infections reported (38) related to tracheostomy colonisations. The hospital told us that both tracheostomy and UTI's were treated accordingly to the sensitivity given by the microbiology laboratory.
- We were shown a clinical audit action plan which was a local audit into rising rates of infection. Data was collated from all patients who had an acquired hospital infection over a 19 month period January 2014 to July 2015. The audit made recommendations for hand hygiene, water supply and screening infection register review, improvement in infectious agent identification and the cleaning and changing of carpets. The dates these needed to be actioned by ranged from October 2015 to January 2016. The hospital confirmed that the audit had not been presented to the clinical governance committee. They

were unable to provide us with results or updates of any of the actions recommended. This meant that the hospital did not have a robust system in place to action lessons learnt.

- The infection control procedure provided by the hospital specified frequency and method of cleaning individual pieces of equipment with a cleaning/ disinfection chart A-Z. This specified that equipment that was not single person use, for example, hoists and gymnasium equipment should be cleaned between each patient using hot water and 'Sure Clean' hard surface cleaner.
- Staff told us equipment was cleaned between each patient use with disinfectant wipes. We did not observe any equipment being cleaned between patient uses. In addition to this staff told us equipment was cleaned at the end of the day and an equipment cleaning checklist was completed. No completed checklists were seen.
- We observed two hoists on level 1 ward which had been portable appliance tested (PAT) but there was no evidence that equipment was cleaned between patients as they both had black dust on them.
- The infection control procedure provided by the hospital specified that suction equipment catheters and accessories were to be single use and be discarded once used. Best practice and guidelines by the United Kingdom National Tracheostomy Safety Project state that tubing used must be single patient use and cleaned as per the hospitals tracheostomy policy. Staff told us that airway tubing was cleaned between patient uses. However, we saw a suction machine with tubing attached that had moisture inside. This indicated it had not been removed following use. There were also white patches within the tubing, which indicated it was not clean.
- Staff in Tobias House confirmed that they were aware that tracheostomy, nasogastric and all airway equipment should be air dried. However we saw that tracheostomy brushes were stood in water in the bathrooms.
- At the time of inspection we saw that shoe covers were not available for use when entering the hydrotherapy pool area. However, during the unannounced inspection we observed that shoe covers were now available for use.
- The National Specification for Cleanliness (NSC) provides guidelines for hospital cleaning. The hospital did not have an operational plan for cleaning or a robust system on which the cleaning was based. Although there is no specific requirement to use the NSC there is a responsibility on the provider of cleaning to have a suitable system in place. NSC is seen as the minimum requirement unless risk assessments have been carried out that reflect local needs.
- We were shown no risk assessments showing why the NSC or a similar system was not in place. We were provided with cleaning checklists prior to inspection but they were not in place at the time of inspection. We were told that the hospital was progressing towards implementing them and were working towards the NSC through using Patient Environment Action Team (PEAT) inspections. PEAT has not been used since 2013 and does not perform the task of monitoring cleanliness solely. This is an overall inspection and used to provide users with a score against four elements: cleanliness, food and hydration, privacy and dignity and maintenance of the environment. PEAT was replaced by Patient Led Assessment of the Care Environment (PLACE) in 2014.
- The Department of Health, Health Building Notes (HBN's) gives comprehensive guidance on the design, installation and operation of specialised building and technology used in the delivery of healthcare. We asked for specific risk assessments as required by HBN 00-09 section 3 for maintenance, cleaning and infection controls involvement; we were told there were no risk assessments. We found that RMC was non-compliant regarding this guidance for shower heads, carpets, wall surfaces, provision of hand wash basins, soft furnishings, and waste and water safety management.
- We asked about the cleaning and descaling regime for shower heads. We were told that this was the responsibility of both the estates and cleaning staff

and was performed by "whoever had the time". None of the cleaning regimes were documented so we were unable to see any evidence that the shower heads were cleaned or descaled.

- Health Technical Memorandum (HTM) 04-01 states in section 3.185 "To minimise the possibility of bacterial colonisation of shower heads, they should be regularly cleaned and descaled". We saw scale on the shower heads in rooms NW3 and SCU6. As there was no evidence as to the cleaning regime for shower heads there was a potential risk of bacteria colonisation on the shower head which would put immuno-compromised patients at risk.
- All of the bedrooms, the bathrooms in SCU, physiotherapy area, outpatients consulting rooms and the hydrotherapy treatment room were all carpeted. We were told that in the event of a body fluid spillage it was immediately cleaned by clinical staff, then scrubbed and mechanically cleaned by the domestic staff. We were told that this was sufficient to put the carpet to a satisfactory condition. Throughout the above buildings there was staining to the carpets which would indicate that the carpet cleaning was not sufficient.
- HBN 00-09 for flooring section 3.108 states "the quality of finishes in all clinical areas should be readily cleaned and resilient" and section 3.109 "flooring should be seamless and smooth, slip-resistant and be easily cleaned". HBN 00-09 section 3.115 for carpets states "carpets should not be used in clinical areas. Included in this are all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances. Aesthetic considerations and noise reduction are most often cited as the reason for using carpets; yet in areas of frequent spillage or heavy traffic, they can quickly become unsightly with staining and offensive smells". Section 3.116 states that "if carpets are to be considered for non-clinical areas (for example, interview rooms, counselling suites or consulting rooms), it is essential that a documented local risk assessment is carried out with IPC involvement and a clearly defined pre planned preventative maintenance and cleaning programme is put in place". We found no evidence of this.
- We found that all the walls in the buildings were covered in an artex type product. The walls were not smooth and the artex material had been applied in such a way as to be of a rough cast finish. Additionally we found damage to the walls and chipped paintwork within the hydrotherapy rest area . Therefore, the cleaning of walls would be difficult and potentially harbouring bacteria in the rough surfaces. HBN 00-09 section 3.119 for wall finishes states "smooth cleanable impervious surfaces are recommended in clinical areas. Design should ensure that surfaces are easily accessed, will not be physically affected by detergents and disinfectants, and will dry quickly. Additional protection to the walls should be considered to guard against gouging/impacts with bedheads and trolleys. Wall surfaces should be maintained so that they are free from fissures and crevices".
- HBN 00-09 building note 3.42 states "the location should provide clinical hand-wash basins and ensure that they were all readily available and convenient for use"'. There was no hand washing basin in the physiotherapy treatment room. Hand sanitizer was available and we observed staff using this before and after patient interactions.
- HBN 00-09 section 3.133 for furnishings states: "soft furnishings (for example seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam free or heat sealed". And section 3.134 states "fabric that becomes soiled and stained cannot be adequately cleaned and will require replacement".
- We observed cushions with stains on them in the hydrotherapy waiting area. Additionally the equipment in the treatment room was unclean. There were two tilt tables. One table had a torn cover which had been partially covered with black adhesive tape and the foam of the cushion was visible. The other table had pieces of the rubber covering on the foot plate missing. Couches in the treatment room had torn fabric and the foam of the cushion was visible. One of the six pillows had a plastic wipeable cover; the other five were fabric and had stains on them. Four sand bag weights had fabric covers which were stained.

Long term conditions

- We checked five mattresses and two pressure cushions across the hospital. All were unzipped to examine and we found them to be clean with no stains or offensive smells. The hospital's infection control procedure had clear guidelines for the testing of permeability of mattress covers every six months using the Water penetration Test as recommended by the Medicines and Healthcare Products Regulatory Agency (MHRA). However, the hospital did not provide us with written evidence of these tests.
- On the day of our inspection we inspected the cleanliness of a section of the main house, Tobias House and SCU. Upon inspecting the physiotherapy gymnasium we found thick dust in the storage cupboards above the couches, thick white dust on the frames of the plinths, white dust on high surfaces and weight lifting equipment. There was ingrained grime on the base and on the hoist, standing aid and the privacy screens. In the hydrotherapy suite we saw a small stepper machine on the floor had a dial missing and thick black dirt was on the surface. Also a standing fan had black dust on it. We were told that all items were cleaned every day and when we pointed out the level of dust on some of the equipment we were told that those areas were cleaned once a week. From the evidence we found it was unlikely the equipment had been cleaned within the last week.
- There were no cleaning checklists for the equipment, so there was no check on what had and had not been cleaned. This meant that items could potentially be missed as shifts changed as there was no record of what had been cleaned the previous shift. Therefore potentially as this equipment was not cleaned to satisfactory level bacteria could transfer from one patient to another.
- We also inspected the bathrooms in the main house, SCU and Tobias House. Within the bathroom area of NW3, level 1, it appeared as if the sub screed had started to crumble as we could feel it under foot. This could lead to the vinyl cracking which would make the floor porous. This would provide an ideal environment for bacteria to multiply and potentially lead to a trip hazard. There was a wooden toilet seat which appeared to not be sealed and sealant around the sink was missing. Both could provide areas where bacteria could multiply. There were no hot and cold markers on the taps which could be confusing for users. There was evidence of scale on the shower head. There was ingrained dirt and grime on the bathroom floor and dark coloured dust on the door frame.
- In room NW7, level 1, we saw thick dust on the mirror, light dust on the towel rail, dark rust on the door closer and thick dust on the wardrobe. Also the carpet was stained.
- The bathroom on level 1 the wall was cracked and there was grime in the grout. Additionally there was floor grout missing.
- In room 3 of SCU we saw light dust on shower curtain track and there was a wooden toilet seat.
- In room 6 in SCU there was dark dust on the door frames, curtain tracks and shower curtain tracks.
- In Tobias House we saw that the floor in the common room was consistently marked with black lines and had black sections throughout.
- The toilets in the hydrotherapy area were clean and of an acceptable condition. However, there were bare wood surfaces within the toilet area. This meant that the surfaces could be porous and difficult to clean. There was a potential for bacteria to multiply and harbour on unsealed surfaces.
- We inspected the waste compound and found the clinical waste section locked. However within the compound four out of the seven bins were unlocked. This could lead to vermin infestation which was possible given the location of the site. As some bins were open and/or unlocked there was potential access for the general public this could lead to hazardous waste being available to the public which potentially could cause harm.
- HTM 07-01 section 5.11 safe management of healthcare waste states: "the segregation of the different waste streams presented is necessary for the following reasons: in England and Wales mixing is prohibited by law; and the producer has a duty of care and is legally required to classify and describe their waste". Additionally failing to describe the mixed waste correctly often leads to its unauthorised disposal. We saw there was a system to separate waste in different

coloured bags to signify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations. However we found that these requirements were not always met in practice. We found in the sluice of the SCU there was domestic waste in the offensive waste stream.

- We found in seven patient bathrooms the waste bin was marked as a clinical waste bin and had a clear bag within this bin. We were told that all clinical waste was disposed of via the offensive waste stream. Therefore the bag should have been yellow with black stripes commonly known as 'tiger' bags.
- We were shown the records for checking the PH and bromine levels in the hydrotherapy pool. This is important as patients could be harmed if either levels are outside the expected range. We were shown the records for the months of August, September and October 2015 and saw that the levels were checked twice daily. In October 2015 there were 16 occasions where the pool levels were out of range. We were told the action that would have been taken on each occasion however there were no actions recorded. We were also told that the pool would be closed on the days when the levels were out of range. However the hospital could not provide any evidence that the pool closed on the days where the levels were out of range.
- We were told that the pool had an annual water safety check for Cryptosporidium. We were shown records from 19 July 2013 that showed the water had been checked and levels of Cryptosporidium were within an acceptable range. We were told that the order had been placed to have the pool checked again but there were no records of it being checked since 2013. This meant that the managers of the pool had no idea if the levels of bacteria in the pool were of a safe level and of a level within range. This could potentially cause patients harm.
- We checked the hospitals records for legionella testing. We saw records of temperature checking of approximately 300 outlets which were checked on a monthly basis. We specifically checked records between July and October 2015. We found that all the temperatures recorded for hot water were between 54ºC and 59ºC and cold water between 13ºC and 14ºC. HTM 04-01 states "the required temperature for hot water to be minimum 50ºC and cold water to be below 20ºC". Therefore, all temperatures were within an acceptable range.
- We asked if a specific risk assessment had been undertaken by as a specialist as part of the water safety management regime. We were told that it had not. HTM 04-01 requires that the hospital arranged annually for samples to be taken from hot water heaters in order to note the condition of the drain water. Additionally every month check temperatures in flow and return at water heaters. Also a six monthly check of the temperature of the water entering the building to be below 20ºC and visually inspect cold water storage tanks and to carry out remedial work where necessary. We were shown no records of the above points which showed there was not a robust water safety management regime in place which could lead to the water being potentially unsafe.
- There was no formal audit process of the cleaning standards. We were told that the health and safety officer did the checks and actions were given to the provider. No percentage pass or fail rate was given and we could find no evidence that an assessment of the risk categories for cleaning had been put in place. The NSC states that each area of the hospital should be assessed as to its risk category and from this assessment a percentage pass rate is generated and the frequency of cleaning is determined. Very high risk areas should achieve 98% and be audited weekly. High risk areas should achieve 95% and be audited monthly. Significant risk areas should achieve 85% and be audited every three months. Low risk areas should achieve 75% and be audited every six months. The low risk category is almost solely used for administration areas.
- The hospital did PEAT audits annually. These would be no use for auditing cleanliness as the audit frequency for all the risk categories required more frequent audits. Without a formal audit score the cleaning department had no idea if the cleaning hours and systems of work were effective and achieving the required standard. Additionally the hospital board would not be aware of any cleaning issues that may occur.

Environment and equipment

- The hospital had been subject to an external review in the last 12 months for ISO 9001 Quality Management

Systems, ISO 14001 Environmental Management Systems and ISO 18001 (OHSAS 18001 Occupational Health and safety Systems).They had also received Investors in People, United Kingdom Commission for Employment and Skills in 2013.

- The hospital told us that they had a process in place for regular equipment checks both from internal and external maintenance sources and a clear preventative maintenance process.
- All electrical equipment had received a portable appliance test in the physiotherapy room, indicated by a label with the date tested on. Electrical equipment had been tested in March 2015. Equipment received an annual service, indicated by a dated sticker on the equipment, confirmed by service records which we saw.
- The hospital had a resuscitation trolley which was kept by the main entrance in Tobias House and an emergency bag was kept in the nurse's office on level 1 in the main building. We were told that all clinical staff knew where the equipment was kept and had access.
- The emergency bag contained all relevant equipment including in date medication, oxygen and a defibrillator which was charged and ready for use. However its service was due April 2015. The emergency bag was checked every week on a Monday and Friday. We saw the record of these checks and they were up to date.
- The resuscitation trolley was sealed with red tags to secure equipment, which were to be broken in the event of use or checking. On top of the trolley was a folder with the hospitals resuscitation policy, Resuscitations Council guidelines, tracheostomy algorithm, defibrillator instruction manual and equipment checklist. The checklist was completed twice weekly and this was up to date. The defibrillator was charged and ready for use and its service was due 10 June 2016. However the single use lead was out of date (July 2015).
- The hospital told us they had a policy for the prevention of fire. During the inspection we looked at fire exits, access and fire prevention equipment available. In the main house there were fire exits at either end of the corridors marked with fire exit signs. There were also directional signs commonly known as 'green running man signs' at the fire exits. The legislation, HTM 05-02: fire code, states "a directional sign should be seen from all parts of the building and at each directional change". This was not the case at the time of inspection. This could lead to confusion and the potential for evacuees to go in the wrong direction.
- We saw the occupational therapy kitchen had fire blankets and a fire extinguisher in place. However, the fire extinguisher was last serviced in 2013.
- The physiotherapy room had a fire extinguisher in place. However we observed there were two small oxygen cylinders and one large cylinder, which was not on a wheeled trolley, positioned in front of the fire extinguisher. The hospitals fire access policy stated fire extinguishers should be easily accessible.
- The fire exit from the physiotherapy room was not wheelchair accessible. Access was obtained via a large step and there was no ramp. HTM 05-02 (3.60) states "final exit doors should not be provided with a step and should open onto an area which is level for a distance of at least 1 metre". Oxygen cylinders had been placed close to the door and this prevented wheelchair access.
- We were told that staff knew the process of how to order equipment but they did not receive feedback about why they did not receive the equipment ordered. Therapy staff in the focus group told us that they have problems ordering equipment and specifically the obtaining of wheelchairs for patients and also the replacement of broken equipment.
- The occupational therapy kitchen was carpeted. There was a piece of carpet on top of the fridge with the kettle on. Food was stored loosely in a cupboard and not labelled in a sealed container. The electrical testing of the plug for the cooker was last done in 2012. We saw the fridge temperature was being recorded but did not have guide to what the correct temperature should be.
- We saw that there was inadequate storage space of equipment in the wards and therapy room. A patient's room on level 1 had a separate wet room which was being used for storage and was cluttered with two wheelchairs. The therapy room was cluttered with equipment that did not enable easy access.

Long term conditions

- Physiotherapy staff told us that in the past they did have the appropriate hoist to enable them to transfer patients onto the nonadjustable tilt table. However, they told us that this hoist had been moved to another ward. The hoist they were using at the time of inspection did not lift patients high enough. Therefore staff had to manually handle patients onto the tilt table.
- The hydrotherapy pool had a deep step up into it which would make it difficult for a person to access with low level mobility. The hospital told us that the pool was designed with a step of that height so users can sit on the step and swing round into the pool allowing easy access. A hoist was available for those patients with mobility problems.
- There was an emergency call bell in the physiotherapy room. We could not easily locate an emergency call bell in the art therapy room but the provider assured us that this was evident.
- The hospital had a service level agreement with Lane Fox Unit at St Georges Hospital regarding ventilators. They serviced the machines and this documentation was observed. The hospital had two reserve ventilators which were used in rotation.
- Nursing staff in the focus group explained that they find it difficult to use moving and handling equipment on carpets.
- Support staff in the focus group told us they do not have a separate staff room to enable them to have a break from work.

Medicines

- The hospital had a policy for the management of medicines and they told us that they had a process for the safe storage and administration of medication. We saw that processes were in place to ensure that medicines were administered as prescribed in a timely manner and were available when needed.
- We observed the records of medicine administration. The prescription charts of six patients were reviewed. We saw evidence of regular medical support to the wards and regularly documented reviews of patient's medicines. We saw records of changes that had been made to patient's prescriptions and clear records of the monitoring required with some medicines.
- We observed good documentation of patient's allergy status and microbiology consultation. These were observed both in the patients' multidisciplinary records and medicine administration records (MARs).
- The hospital had a service level agreement with a local pharmacy who reviewed patient's medication. The pharmacy audited and advised to ensure medications were clinically appropriate and to optimise the outcomes.
- Medicines were ordered from the community pharmacy (a local chemist) in a 28 day cycle period. Medicines were supplied in original packs and any additional medications required would be prescribed on a private prescription and faxed to the pharmacy to supply. Two sets of MAR sheets were supplied with medications. One was used to record the administration of medicines and the other was used for re ordering medicines. Ward nurses were responsible for identifying which medicines needed to be ordered. The MARs sheet was signed by a doctor before sending to the pharmacy for dispensing to individual patients.
- There were arrangements for staff to obtain medicines when these were required urgently.
- We asked staff if any medication incidents had been reported. We were told about an incident when a medication had been administered twice as the first administration had not been signed for on the MAR. The doctor was informed and an incident form completed. The outcome of this incident resulted in the process of medication administration being changed on the wards. One designated registered nurse was responsible for the administration of medications on each shift and there was an improved communication at handover.
- We saw that the hospital had some patients who had their medicines administered covertly. Covert administration required the crushing of medications and administered with food. Best interests' forms were completed and kept in the patients' medical records. However, we saw that these best interests' forms had not been signed by a pharmacist even though this was a requirement of the form.
- We saw the appropriate prescribing and recording of the administration on the MAR sheet for 'when

required' medications. These included maximum dosage and indication for treatment. However, there were not consistently personalised protocols in place for all 'when required' medications.

- We saw individualised protocols in place for seizure management for some patients. These protocols were kept in the patients multidisciplinary records but we did not see any copies with the patients MAR sheets. We were advised that intramuscular diazepam was administered by registered nurses and we saw appropriate records of the administration of this medication.
- The provider told us antibiotics were prescribed in accordance with local guidelines and these were displayed in the doctor's office. Our review of antibiotic prescribing identified significant use of antibiotics, including broad-spectrum antibiotics, in some patients. We did not see auditing of antibiotic use at RMC despite them identifying high rates of recurrence of infections. An infection audit had been completed prior to inspection but had failed to review the use of broad spectrum antibiotics or consider whether prescribing was in line with local guidelines.
- We found that medicines were kept securely with controlled drugs (CD's) stored in suitable cupboards with records maintained. The CD's cupboards were locked, with restricted access, and were bolted to the wall.
- Other medications were stored in the medicines trolleys which were kept in the medication storage rooms which were locked and chained to the wall. However, we saw that the medication storage rooms were small with insufficient storage space and limited worktop area available for the preparation of medicines.
- We observed the use of a domestic fridge in the SCU for medicines requiring low-temperature storage. The hospitals policy states "medicines stored in the fridge must be kept at a temperature of between 4 and 6 ºC and checked daily for temperature control and cleanliness". We saw regular recording as per the policy for minimum and maximum temperatures. However, the fridge in SCU showed recordings of above 8ºC throughout November 2015 with no action evident. This could impact on the safety and efficacy of medicines.
- We saw that ambient room temperatures in the medication storage rooms were checked and recorded daily. These were within the acceptable range (18-25ºC).
- We observed the appropriate storage of oxygen cylinders as part of the emergency medicines. We also saw that the larger oxygen cylinders were stored in appropriate holders but were stored in the corridor.
- We saw regular auditing of medicines storage and administration. We also saw some individualised protocols detailing how 'when required' medicines should be given, although we did not see this consistently.
- The controlled drugs accountable officer (CDAO) told us that they checked current balances and second signatures for CD's on a monthly basis. However, this was an informal process and the CDAO acknowledged there was not a formal auditing process for controlled drugs in place. We were not supplied with documentation of any controlled drug audits. The CDAO told us they were also responsible for the daily management of controlled drugs.
- The hospital CDAO is responsible for establishing, operating and reviewing the appropriate arrangements for safe management and use of CD's. However, the CDAO at the hospital was also involved in the administration and disposal of CD's as part of their daily duties. This did not meet the conditions for appointment to the CDAO role set out in The Controlled Drugs (Supervision of Management and Use) Regulations 2013, section 4.

Records

- We saw that patient's records were multi-disciplinary (MDT) in that doctors, nurses and therapists contributed to a single unified document. This ensured that relevant information was not omitted and that the entry was easy to follow and understand.

Each patient also had bed side notes which were completed and transferred with the patient when they attended treatments. We saw that these notes were transferred to the MDT notes on a daily basis.

- On level 1 and level 2 wards in the main house we observed a total of nine records and in Tobias House five records. We saw that records were well maintained and easy to navigate. They were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. Patient records were readily accessible to those who needed them.
- The 14 records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received.
- The notes we saw in Tobias House the nursing records were clear but therapy activities were not always evident. However during the unannounced inspection we saw an improvement. We observed the therapists input into the MDT notes for two patients on level 2. We saw that the therapists had recorded all interventions which were recorded comprehensively with reference to subjective, objective, assessment and plan (SOAP) guidelines. They defined the patient's goals with evaluation and had consent and best interest decision documented.
- The British Society of Rehabilitation Medicine (BSRM) recommends standards of best practice for care for patients with a complex neurological disability. Each patient should have a timed set of outcome goals that involve their family and coordinated by the MDT. The goals should be reviewed at a frequency appropriate to the patient's management and be combined with appropriate outcome measures.
- The hospital and staff told us that each patient had a six weekly meeting to evaluate and decide future goals. They told us everyone was involved in the goal planning and this was recorded in the medical notes. In the 14 records we saw there was not clear documentation of these six weekly goal setting meetings.
- When a patient attended a therapy session their bedside notes went with them. However, the goals were not documented in these notes. We asked staff how they knew what the goals for the individual patient were, to which they replied with "they just did". They did not tell us if they were able to access the patient's record on the computer.
- A national initiative introduced for standards and guidelines for tracheostomy care by the Intensive Care Society (2013) advised that all patients with a tracheostomy have a tracheostomy passport which ensures consistency in practice as patients move between home and hospital. These passports were observed for tracheostomy patients in the Tobias House.

Safeguarding

- The hospital told us they had a robust policy for safeguarding reporting along with designated safeguarding and patient safety champions to whom staff had access. We were told that there were clear processes in place for the reporting of any concerns. The RMC adult protection policy 2015 contained a flowchart for reporting concerns and the relevant local authority and social services numbers were available for staff.
- The hospital told us that they had a safeguarding lead that was supported by the director of nursing and hospital director. The safeguarding committee met quarterly.
- We were shown the safeguarding adult alert log for 2014. This contained four recorded incidents. All four incidents recorded a case conference, outcomes concluded and action plans for lessons learned.
- Providers are required to provide a statutory notification to the CQC if any of their patients are involved in a safeguarding incident. We reviewed our records and found that we had not received statutory notifications for the alerts on the hospital's own log supplied. This meant the hospital was not reporting all safeguarding incidents as required by the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.
- We spoke to nursing and support staff in the focus groups and staff on the wards who demonstrated a

good knowledge and understanding of safeguarding vulnerable adults. They knew the process if they had concerns regarding the treatment of a patient and knew to report to the safeguarding lead.

- Staff on level 1 ward told us that they were aware of who the safeguarding lead was. They knew the escalation procedure but were unable to provide us with examples that safeguarding was discussed at MDT meeting.
- Safeguarding was part of mandatory training and was annual. All staff groups receive safeguarding training and the safeguarding lead told us that, at the time of inspection, 92% of staff had been trained. We were told that support staff were the hardest group of staff to get to attend training. We saw an audit that was completed that showed the comparison between September 2014 and December 2014 of staffs learning and competencies after level 2 safeguarding training. The audit showed an increase in staff awareness.

Mandatory training

- The hospital told us that all staff undergo regular mandatory training including safeguarding. The hospital had a clear induction process and competency assessments appropriate to the staff role. However, the practice of neurorehabilitation was not part of mandatory training contrary to recommendations of the Independent Rehabilitation Providers Alliance.
- We were shown the annual mandatory training planner for 2015 for all staff. Throughout the year there were two different topics covered each month. Topics covered were COSHH, challenging behaviour, health and safety, moving and handling, confidentiality and data protection, risk assessment, food hygiene, stress management, pressure area care, code of professional conduct, infection control, fire safety, the Mental Capacity Act, Deprivation of Liberty Safeguards, basic first aid and emergency first aid. There was also additional training sessions for safeguarding adults planned for nine months of the year. Data from the hospital showed that during the period January 2015 to September 2015, 80% of staff had attended all relevant mandatory training, but the RMC's target for compliance with mandatory training was unclear.
- Therapy staff had access to mandatory training twice a week on a Tuesday and a Friday. Sessions included health and safety, COSHH, safeguarding, basic life support and first aid. The training sessions were organised by administrative staff who informed therapists via email. Staff told us they did not keep their own records of attendance although they were aware that evidence of training is required to maintain their professional registration.
- Staff told us that they received face to face mandatory training in cardio pulmonary resuscitation (CPR), moving and handling, fire safety and infection control.
- We were shown a copy of the hospitals two day core induction programme for all staff. All the training was provided either by watching a DVD or the candidate reading a hospital policy.
- Health Technical Memorandum (HTM 05-01) provides guidelines for fire safety training. Additional training should be provided to meet the special needs of particular locations and for those staff who have special responsibilities (11.13). The fire safety training programme should include practical sessions and fire drills to supplement classroom instruction (11.16). Also E-learning is not acceptable as the sole means of training (11.18). The hospital told us that fire training was undertaken via the staff watching a DVD on E-Learning. Staff did not receive different training for staff groups even though problems may be encountered if evacuation was needed for different patient groups and specific areas.

Assessing and responding to patient risk

- BSRM Specialist Nursing Home Care for people with Complex Neurological Disability: Guidance to Best Practice 2013 recognises that the majority of people with severe physical or cognitive disabilities are at great risk of complications from their condition and are likely to deteriorate. It is vital that these people are managed in an institution that can meet their needs and that these institutions deliver a good standard of care commensurate with the fees they are charging. An early warning system such as the National Early Warning Score (NEWS) is recommended. Introduced by the Royal College of Physicians it is a tool used by medical services to quickly determine the degree of illness of a patient.

Long term conditions

- We were told that the hospital did not use an early warning system. Both the consultant and a ward manager dismissed the need for it. Both stated that they observed their patients "very well and did not require the use of a specific tool". However we noted that observations were completed fully and consistently in patients records.
- We saw that patients were risk assessed in key safety areas using nationally validated tools. For example we saw that the risk of malnutrition was assessed using the MUST tool and the risk of pressure damage was assessed using the Waterlow scoring tool. MRSA screening was completed. Additionally we saw that the records contained useful photographs for positioning and posture of patients for both bed and chairs. We noted that when risks were identified relevant care plans which included control measures were generated. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales.
- The hospital told us that between July 2014 and June 2015 a total number of 17 patients were transferred to another health care provider. Eight of these episodes occurred at night. Most of these incidents related to either seizures or desaturation which RMC were unable to resolve.
- We were told that senior staff were all trained in immediate life support (ILS) and unqualified staff have basic cardio pulmonary resuscitation (CPR) training. The hospital provided simulation exercises that tested staff on their response and performance in the event of an emergency resuscitation situation. We saw the records for four of these sessions and the lessons learned.
- We observed a patient before they went for oil dispersion therapy treatment. The therapist monitored and observed the patients vital signs (blood pressure, auxiliary temperature, pulse and respirations) and these were recorded in the patient's bed side notes which accompanied them to the therapy room. The observations were than taken again as the treatment started and post treatment. These were all recorded. When the patient returned to the ward the nursing staff obtained and recorded the observations 30 minutes later. We saw that all of these observations were documented in the patient's bed side notes which are transferred to the multi-disciplinary notes at the end of the day.
- Staff received medication alerts from MHRA which were emailed to the wards via the generic email address. Staff told us they checked this on a regular basis. We saw an alerts folder on the wards which contained the policy, copies of recent alerts and records of the actions taken.

Nursing staffing

- Nurse staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.
- We saw the off duty for nursing staff for September to November 2015. The actual number of staff working matched with the agreed number recorded on the off duty.
- Level 1 ward which had 21 patients, had two qualified nurses and 13 unregistered staff on the day shift and one qualified and five unregistered at night.
- Level 2 ward which had nine patients, had one qualified nurse and five unregistered staff on the day shift and one qualified and two unregistered at night.
- SCU had eight patients, had one qualified mental health nurse and five unregistered on the day shift and one qualified nurse and two unregistered staff at night.
- Tobias House had nine patients had one registered nurse and five unregistered on the day shift and one qualified nurse and two unregistered staff at night.
- The hospital told us that nurse staffing levels were reviewed in line with patient acuity and this process started at the pre-admission assessment of a referral. For example if a potential admission required one to one nursing support then staffing would be increased if providing such a service would be detrimental to existing staff levels. We saw on the off duty that

patients who required one to one nursing support were allocated a specific member of staff to accommodate this without affecting the agreed number of staff.

- The hospital employed 32 full time equivalent nursing staff. They had four full time equivalent vacancies for nursing staff.
- The majority of staff recruited by the hospital were from Eastern European countries where they had practised as registered nurses. They start as support workers at RMC and when they acquire their registration they were able to practice as registered nurses.
- The hospital was unable to provide a percentage of the average rate of sickness for nursing staff or health care assistants over the previous three months.
- We saw no evidence of bank or agency use and we were told that wards borrowed staff from other areas to cover sickness. There was a heavy reliance on care support workers rather than registered nursing staff. The hospital told us that in the three months prior to inspection no nursing shifts were covered by bank or agency staff. However, the information provided by the hospital showed that during the same period 150 health care assistant shifts were covered by agency staff.
- Nursing staff and care workers were contracted to work a 42 hour week. They worked a 12 hour shift and during a week they were rostered to work three long days and one half day.
- Each patient was assigned two key workers who worked opposite shifts (day/ night) to provide continuity for patients. Every Wednesday afternoon the off duty allowed the two key workers to work together to enable them to handover about their specific patients.
- Staff told us there were two handovers for staff every day. These were between 7.30 am and 8.00am and 8.00pm to 8.30pm.

Allied health professionals

- The hospital had a large therapy team that included physiotherapists, occupational therapists, psychologists, speech and language therapists, art therapists, music therapists, drama therapist, eurhythmy and external application therapists. Therapist staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation medicine (BSRM), the National service Frameworks for Long term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on prolonged Disorders of Consciousness.
- The hospital told us that therapist staffing levels were regularly reviewed in line with patient acuity. At the time of inspection the hospital employed 28 full time equivalent therapists and had one full time equivalent vacancy.
- The head of therapy told us that recruitment was achieved through advertising in professional journals. Additionally successful applicants were recruited owing to the individual's clinical expertise rather than the anthroposophical principles of the hospital.
- The patient survey completed by the hospital highlighted that therapies and treatments were often cancelled due to staff shortages and holidays.

Support staff

- Support workers at the hospital included administration, domestic, estates and kitchen staff. The hospital did not provide us with data of how many support staff were employed.

Medical staffing

- The hospital told us that all patients were under the care of a consultant for their relevant conditions. The hospital employed a rehabilitation consultant, and psychiatrist consultant.
- The rehabilitation consultant worked each week on Saturdays and Sundays during the day. Medical care was provided by a resident doctor who worked daily 8am to 8pm.They told us that they had two weekends off a month and this was covered by another doctor employed by the hospital under rules or practicing privileges. The resident doctor was on call out of hours and reported that they received calls two or three times a month.

- The consultant psychiatrist worked two days a week on a Thursday and Saturday.
- The head of therapy was the psychologist lead and supervised three assistant psychologists. The head of therapy was a full time employee, doing four clinical sessions per week and was also the safeguarding lead.
- The hospital directly employed two full time equivalent doctors and four part time doctors under rules or practicing privileges. The hospital had one full time equivalent vacancy for a doctor.
- Medical staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.
- The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. There should be evidence that the provider has complied with legal duty to ensure that the regulation 19 in respect of staffing and fit and proper persons employed are complied with. Where practising privileges are being granted, there should be evidence of a formal agreement in place.
- The hospital showed us their Guidelines for the Development of a Practising Privileges Policy for Consultant Medical Staff which was written November 2015. This was a copy of a suggested template by the Independent Healthcare Advisory Services (IHAS) for provider groups to consider when developing their own document. The hospital told us they had four doctors working under practising privileges but were unable to provide documentation of a formal agreement that set out the rules and conditions of their employment.

Major incident awareness and training

- The hospital provided us with a risk management policy for business continuity planning which was ratified by their clinical governance committee. This listed the immediate threats to business continuity for flooding, adverse weather conditions, fire, utility failure and disease. This five page document explained that its purpose was to plan how the organisation would recover and restore interrupted critical functions after a disaster. However, the reader was advised to see further policies and procedures for each individual threat. For example fire precautions policies and procedures and preventative maintenance planning.
- The hospital also provided us with a 'human side of business and technical plan' where the hospital had a plan designed to assess how well it was prepared to handle the human dimensions of a disaster. This plan identified the threats but did not advise on what staff were actually to do in the event of a disaster. The plan we saw was not robust because it only identified environmental risks with no consideration of clinical risks. The mitigating actions (titled solutions in the document) were not explicit in the preventative actions staff should take, nor did they explain clearly actions they should take should one of the identified threats become a reality. For example the solution suggested for the threat "Heat Control" only stated "Thermostat controlled heating system, ventilation, in the rooms/departments where heat is unavoidably excessive (kitchen, laundry) open the windows and if possible use a fan." There was no categorisation of the severity of the risk based on its likelihood or potential impact recorded.
- Staff told us that major incident training was not covered in any depth. However, we saw that that all patients had a personal emergency plan in their records. This explained the arrangements of how to transport the patient in the event of an emergency situation.
- They told us that they had fire drills on a monthly basis which were recorded. We did not ask to see the records. However, staff we spoke with told us that they had not had a fire drill recently.
- Therapy staff told us that they practised a hydrotherapy emergency evacuation procedure twice a year and the target required was under three minutes. We observed that this was documented in a diary which recorded who had attended and the

length of time the procedure took. The last recorded practice was 11 November 2015. Staff told us they followed a documented procedure and we saw this documentation.

- We asked therapy staff about the emergency evacuation procedure for immobile patients who were in the oil immersion bath. Staff told us that they leave the patient on the sling in the bath so they can be removed quickly. We asked staff if they practice for an emergency. We were told that every day they get people in and out of the bath quickly, so they did not need to practice.

Are long term conditions effective? (for example, treatment is effective)

We looked at how effective the hospital was. We found that RMC required improvement regarding evidence based guidelines, auditing patient outcomes, registration of therapists and staff who work under rules or practicing privileges.

The hospital aimed to provide a service using the relevant guidance, standards, best practice and legislations relevant to rehabilitation services. However, the policies we observed were not robust. The hospital had acknowledged national guidelines in the policies but these were not fully reflected in their content or presentation of the guidelines.

The hospital was not proactive in monitoring patient outcomes. Information on rehabilitation requirements was collected as a multi-disciplinary team and sent monthly to United Kingdom Specialist Rehabilitation Outcomes Collaborative (UKROC) database but there was no evidence of outcomes or benchmarking as a result of input into the UKROC database.

We saw data that confirmed if staff received an appraisal. There was not a formal system in place to track themes or trends identified at appraisals.

Medical, clinical, therapy and support staff worked with nurse specialists together to provide a multidisciplinary approach for the care of the patient.

The day to day medical service was provided by the in house physicians everyday 8am to 8pm and then on an on-call basis. Consultants provided a 24 hours on call service. Patients had access to therapy service seven days a week 8am till 8pm.

Patients were screened for the risk of malnutrition and patients who received artificial nutrition support via feeding tubes were reviewed regularly by the speech and language therapist (SALT). The hospital provided food in keeping with their anthroposophical ethos. Patients and staff we spoke with told us that although the choice of menu was limited the food was nice.

We saw there were clear procedures for patients subject to the Mental Health Act as well as for Deprivation of Liberty Services (DOLS). The 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decision making process complied with national guidelines.

Evidence-based care and treatment

- Professional standards and evidence based guidance relevant to rehabilitation services include: BSRM Guidelines, National Service Framework for Long Term Conditions, the Royal College of Physician Guidelines for Acquired Brain Injury and Prolonged Disorders of Consciousness (PDOC), Specialised Services National Definitions Set (SSNDS) and National Institute for Health and Care Excellence (NICE) guidance.
- The hospital delivered care in line with BSRM guidance. They ensured that all patients with a severe disabling illness or injury were assessed by a consultant in rehabilitation medicine or their designated deputy in line with NHS England and BSRM's framework.
- All patients had their needs assessed on admission and all relevant care plans, risk assessments and protocols were put into place within the time frame specified by BSRM guidelines. A checklist was available within the care plan to ensure these were done in a timely manner.
- We saw that the hospital had incorporated the quality requirements of the National Service Framework for Long Term Conditions. It provided a person centred

service, community rehabilitation and support, vocational rehabilitation, and provided equipment and accommodation to support them to live independently.

- We saw that the hospital had developed their service for patients who were in altered states of consciousness in line with the Royal College of Physicians Guidelines for people with PDOC. They utilised the recommended structured assessment tools to aid accurate diagnosis and to monitor patients. For example they used the Wessex Head Injury Matrix (WHIM) and the JFK Coma Recovery Scale. The provider ensured that all patients were provided with appropriate diagnosis and we were told that they would seek further opinions if required.
- The hospital told us prior to inspection that they ensured the service they provided was effective using the relevant guidance, standards, best practice and legislations and these were incorporated into their policies. However, the policies we observed were not robust. The hospital had acknowledged national guidelines in the policies but these were not fully supportive in their content or presentation of the guidelines.

Nutrition and hydration

- NICE Guidance CG32 (2006) Nutrition support for adults: oral nutrition support, enteral feeding and parenteral nutrition advises on best practice for the care of adults who are malnourished or at risk of malnutrition. Screening for the risk of malnutrition should be carried out by healthcare professionals with appropriate skills and training. An appropriate tool for screening is The Universal Malnutrition Screening Tool (MUST). People should be screened on admission and when there is a clinical concern. We saw in patients notes that MUST assessments were completed in a timely manner.
- We were told of a situation when a patient on admission was malnourished with a Body Mass Index (BMI) of 15. Cohesive working between medical, nursing, kitchen staff and relatives enabled the patient to eat a normal balanced diet and increase their BMI to 22.
- At the time of inspection the hospital had 42 patients who received artificial nutrition support via feeding tubes. We saw that patients swallowing ability was regularly reviewed by the speech and language therapist (SALT).
- The hospital told us that food provision and the manner in which food is given to patients is an important part of their therapy in normalising their routines and as a consequence, their recovery. At the start of treatment following injury, many patients were unable to eat normally and received artificial nutrition support via feeding tubes. As treatment around speech and swallow improved concurrent with intensive speech and language therapy many patients were able to manage food orally.
- The hospital told us that in keeping with their anthroposophical ethos, all foods chosen, where possible, were organic, freshly prepared and free from additives. The chefs worked with the dietician and SALT team to provide suitable menus in keeping with the standards required.
- The hospital had a set weekly menu. A roast dinner on a Sunday, vegetarian dishes on Mondays and Thursdays, fish dishes on Tuesdays and Fridays and meat dishes on Wednesdays and Saturdays.
- Observations we made in the dining room showed that staff provided patients with support for feeding if required. We spoke with five patients regarding the menu. Four patients were positive about the food and one patient was negative. Two of these patients complained there was a lack of choice. However, they told us the food was always hot when served.
- Staff were provided free food and drinks. Staff we spoke with told us that although the choice was limited the food was nice. Staff told us that if they could change one thing to make their working life better they would change the present menu as it was too restricted and planned.
- The dietician carried out an audit in November 2015 to evaluate meal provision for patients. The audit showed that of the 34 patients able to have food from the menu 90% of patients requested food that was not

listed on the menu. Between 25-50% of food was wasted most days and 80% of food was wasted on Mondays and Thursdays which were the vegetarian menu days.

- The results of the audit recommended that the current menu be updated to meet the needs of patients with different consistencies and special diets. Additionally to offer choice within the menu and this should reduce the amount of food wasted. Due to timescales we acknowledge that the hospital had not the opportunity to progress the findings.

Patient outcomes

- The hospital told us that they audited patient outcomes via a number of processes. Using a goal setting approach to patients rehabilitation, the regular multidisciplinary team review played a significant part in auditing a patients outcome to given therapies. Outcome was also reviewed using individual standardised measures, for example, the Wessex Head Injury Matrix (WHIM) was used in auditing outcome in PDOC. The Functional Independence Measure and the Functional Assessment Measure (FIM FAM) were used in auditing functional changes. The Rehabilitation Complexity Scale was used in auditing changes in level of need.
- The United Kingdom Specialist Rehabilitation Outcomes Collaborative (UKROC) developed a national database collating all specialist neuro-rehabilitation services (level 1 and 2) across the UK. It provides information on rehabilitation requirements, the inputs provided to meet them, outcomes and cost benefits of rehabilitation for patients with different levels of needs. In collaboration with the British Society of Rehabilitation Medicine (BSRM) it is a payment by results improvement project. It provides information on case mix and episode costs to inform the development of complexity weighted tariffs. Units using this flexible tariff must be registered with UKROC and report serial data and demonstrate that they are able to provide inputs commensurate with patient's needs.
- At the time of inspection the hospital told us that they had a 14 level 1 and 26 level 2 patients and they submitted data to UKROC for level 1, 2a and 2b patients.
- The neuro-rehabilitation consultant told us that information was collected as a multi-disciplinary team and sent monthly to UKROC database. However, the hospital was unable to provide us outcomes of this data. We were told by the therapy lead that there was no evidence of outcomes or benchmarking as a result of input into the UKROC database. They told us they were unable to retrieve data as they had no administration support.
- Formal service reviews were carried out during Medical Advisory Committee (MAC) meetings and clinical governance meetings. Reviews around individual patients needs were held during case review meetings.
- The purpose of these reviews included ensuring the provider was making progress in delivering quality markers assigned by national standards and guidelines. Additionally they ensured that the service had adequate staffing levels, facilities, equipment and range of service provisions. The provider also believed partnership with other agencies was vitally important so reviews also considered what might be improved in partnership development.

Competent staff

- Staff told us they had received appraisals and specific personalised professional goals had been agreed. The director of nursing confirmed that there was not a formal system in place to track themes or trends identified at appraisals.
- At the time of inspection 38 health care assistants had been employed for more than 12 months and 73% had received an appraisal.
- Twenty seven nurses had been in employment for more than 12 months. Of these nurses 70% had received an appraisal and 100% had their registration checked.
- The Nursing and Midwifery Council (NMC) is a regulator and maintains a register of all nurses eligible to practice within the UK. We observed the records of three registered nurses and saw that all three registrations were in date. We also observed the daily printout provided by the hospital which showed that registrations were up to date.

Long term conditions

- Thirteen therapists had been in employment for more than 12 months, 97% had received an appraisal and 100% their registration checked.
- Data provided by the hospital showed us that the two doctors employed had both received an appraisal and had their registration checked in the last 12 months. The senior registrar confirmed that their appraisal was completed by a consultant and their revalidation was valid.
- The hospital told us that 100% of the current number of staff who work under rules or practicing privileges had an appropriate level of professional indemnity insurance in place.
- The hospital told us that all staff were encouraged and supported to attend Continuing Professional Development (CPD) events, training and conferences. This ensured staff had access to the most up to date information around patient care and quality markers. Staff were expected to disseminate their learning to teams on their return.
- Staff described a comprehensive system of clinical supervision and managerial supervision for therapists. The hospital 'buys in' an external physiotherapy service to provide professional and managerial supervision for physiotherapists.
- The SCU was led by the ward manager who was a qualified mental health nurse and was supported by qualified mental health nurse team leaders.
- A respiratory specialist nurse from St Georges Hospital provided training for tracheostomy care and ventilated patients. A specialist nurse from the Lane Fox Unit visited every week to review ventilated patients and adjust settings. They worked very closely with the resident team.
- We asked staff regarding their competencies. They confirmed that they receive training on induction and then annually. We saw the completed competency programme for nursing staff.
- Staff we spoke with explained they had a positive experience of the induction process and explained they were encouraged for ongoing learning and development.
- We were told by staff that only one nurse was trained in the replacement of artificial nutrition feeding tubes. This meant that when this person was off duty a patient would have to be admitted to an acute hospital for treatment. However the provider disputed this and informed us there were four staff competent in insertion and replacement of artificial nutrition feeding tubes.

Multidisciplinary working

- We asked the hospital to describe how they ensured the involvement of local authority social services staff where necessary. They explained that all patients were referred by, and then subsequently funded by, their relevant Clinical Commissioning Group (CCG). All commissioners were invited to attend case conferences. The first one occurred eight to ten days following admission, then at six weeks and three monthly after. If commissioners failed to attend then a detailed report was sent to them to keep them fully informed. Discharge planning was commenced on admission and guided by the discharge committee. This process was closely coordinated with the relevant local authority social services team.
- The hospital told us that they received 89 referrals for admission between July 2014 and June 2015. Sixty one of these patients had complex disabilities. The hospital told us that all patients were assessed within two weeks of the referral.
- We were told that every six weeks there was a case presentation for patients. This involved all members of the MDT, the patient and their relatives. At this meeting the patient's progress and individual goals were discussed and planned. However, the patient records we observed did not show clear documentation of the goals discussed at these meetings.
- The SCU accommodated patients who presented with a dual diagnosis. For example a patient with an acquired brain injury and pre or post trauma psychiatric conditions. The unit was led by the consultant psychiatrist and supported by the consultant in rehabilitation medicine.
- Medical staff told us that 30-40% of the in patients had a tracheostomy that were reviewed and monitored by the SALT team. Medical staff and the SALT team met every Wednesday to discuss and review patients.

- The dietician worked at the hospital two days a week and was knowledgeable in their role. They told us they review a patient within a week after their admission to monitor their feeding regime. The dietician met with the doctor every Wednesday to review patients and discussed patients with the SALT team on their working days. Staff were able to communicate specific concerns to the dietician via a folder left in reception.
- The therapy lead told us that they encourage the therapist team to contact staff who have been caring for patients in previous places of care. Especially if there was insufficient information received in the referral documentation.
- At the focus group for nursing staff all the staff spoke positively about their experience working at RMC and told us everybody worked as a team and supported each other. They were not asked to work outside their scope of practice.

Seven-day services

- The hospital told us that consultants provide a 24 hours on call service as and when required. The day to day medical service was provided by the in house physicians who dealt with any routine and emergency situation in consultation with the relevant consultant assigned to the patient. Each day after 8pm medical cover was provided by telephone advice.
- Staff told us they were confident to contact the doctor out of hours and they didn't feel it was necessary for a doctor to be on site 24 hours a day. They would contact emergency services for a deteriorating patient if required.
- Patients had access to therapy service seven days a week 8am till 8pm.
- The dietician worked at the hospital three days a week and was knowledgeable in their role. Staff were able to communicate specific concerns to the dietician via a folder left in reception.

Access to information

- We saw that patient's records were multi-disciplinary in that doctors, nurses and therapists contributed to a single unified document. This ensured that relevant information was not omitted and that the entry was easy to follow and understand. Each patient also had bed side notes which were completed on a daily basis and transferred with the patient when they attended treatments. These notes were transferred to the MDT notes on a daily basis.

Consent, Mental Health Act and Deprivation of Liberty Safeguards

- Information provided by the hospital prior to inspection informed us that eight patients had a mental health disorder and were in receipt of a formal care plan under the Care Programme Approach. Thirty six patients were subject to an authorisation under the Deprivation of Liberty Safeguards (DoLS). However, the safeguarding lead for the hospital told us that they were unaware that they had to complete a statutory notification of DoLS to the Care Quality Commission (CQC) for all patients subject to a DoLS authorisation. We had not received any notifications for the 36 patients subject to an authorisation at the time of our inspection. This meant the hospital was not complying with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The hospital told us that there were clear procedures for patients subject to the Mental Health Act (MHA). We reviewed arrangements for the detention of patients under the MHA and they were robust, compliant with legislation and known by staff..
- Staff told us they recorded DoLS on electronic files and these were monitored by the safeguarding lead. The records we observed had completed appropriate DoLS records in patient's notes, recognising that staff worked in the patient's best interest.
- We saw that assessments of capacity were carried out using a standardised template that ensured the requirements of the MCA Code of Practice issued by the Department of Health were met.
- The hospital had a policy which contained guidelines adhering to national guidance with regard to restriction and restraint in order to ensure restraint was only used when appropriate.
- We observed in Tobias House there were risk assessments available for the three types of restraints available for use. These were lap, foot and head straps.

Long term conditions

Do Not Attempt Cardio-Pulmonary Resuscitation Orders

- Medical staff we spoke with understood the 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decision making process and described decisions made with patients and families. They told us they provide clear explanations to ensure that the decision making was understood.
- While visiting ward areas we checked medical records and we viewed two DNACPR forms that complied with national guidelines. We saw that all decisions were recorded on a standard form, signed by an appropriately senior clinician and evidenced that there had been discussion with the patient or relative. The form was kept in the front of the patients notes.
- The Resuscitation Council (UK) guidelines state that every organisation must have at least one resuscitation officer who would be responsible for audit of DNACPR which is mandatory. The hospital confirmed that they do not audit DNACPR forms.

Are long term conditions caring?

Feedback from patients and those close to them was positive about the way staff treat patients. Staff were observed to be kind and caring with a compassionate attitude. They built positive relationships with patients and those close to them and spent time talking with them. Patients valued their relationships with staff.

Staff involved patients in their own care and treated them as partners. Each patient was assigned two key workers who worked opposing shifts to provide continuity of care for patients. Patients were supported to increase and maintain their independence.

Verbal and written information enable patients to understand their care and met their communication needs.

Compassionate care

- Overall the staff, in all areas of the hospital, were caring, well-meaning and showed they genuinely cared for the patients. We saw staff provide dignified and respectful care to patients and they had good knowledge of the patient's individual needs.
- A consultant explained to us that as an independent hospital and family run business they were able to provide a better service for patients with the environment, attitude and work ethic. They felt they were able to "go the extra mile". Patients and relatives got to know staff and were able to build good relationships.
- A member of the clinical team told us that the care patients receive at RMC was "second to none and I would be very happy for a relative to be cared for here".
- We spoke to four patients and seven of their relatives regarding the care received at RMC. They all shared positive comments.
- We were told that staff were very compassionate. They respected and maintained patient's dignity. They said there was enough staff to meet their needs and they liked having regular carers.
- Patients told us they liked their rooms and one patient told us their room was "very pleasant and quiet".
- A relative of patient told us that "staff are nice and they go home after visiting their relative knowing that they are being looked after".
- A relative explained to us how their relative had "improved since their admission to RMC as the whole ethos of the hospital is that everyone will improve. There is coordination between professionals and relatives support each other". Another relative told us their family member did not start recovering until their admission to RMC, and now have a chance of recovery due to receiving therapy seven days a week.
- We saw that patient's individual dignity was not respected in the therapy room. The treatment beds did not have curtains around them. We saw that there were screens available for use but we did not observe these being used during our inspection.

Understanding and involvement of patients and those close to them

- Before inspection we provided the hospital with feedback boxes that enabled patients and their relatives to complete anonymous comment cards about the hospital. We received 13 comment cards back. There were 10 positive and three negative

responses. Positive comments were around good care received, amount of therapy received and progress made by patients. Negative comments were around poor hygiene, lack of stimulation and no personalisation of rooms.

- Patients and their representatives were involved in the decision making process from pre admission through to discharge. The hospital told us that they provided all necessary information, in appropriate formats, about treatment and care and were supported to fully understand the implications. Using a goal setting approach was paramount to their involvement and working in partnership supported each patient's individual decision making process of their treatment and care. Each patient had their own individualised care plan and both the patient, where possible, and their family were involved in the process. Patients and their representatives were invited to attend the consultant's weekly ward round and all case reviews. Relatives we spoke to confirmed they were invited to case reviews.
- Each patient was assigned two key workers who worked opposing shifts to provide continuity of care for patients. Patients and their relatives told us they liked having regular carers.
- We saw that the hospital encouraged relatives to be involved in patients care. We saw examples of relatives being involved in personal care and attending therapy sessions with patients. Staff in Tobias House told us that they encouraged the involvement of relatives in the risk assessment of patients. We were told examples of relatives being taught the correct moving and handling techniques.
- The consultant gave us an example where a relative had read about a specific treatment that would improve cognitive impairment of a patient. The consultant researched the evidence and was able to confidently communicate with the relative the inappropriateness of the treatment requested.
- The hospital told us they not only provide support for the patient but also their relatives. They provided information of community services as well as services within the hospital. The hospital provided brain injury awareness training to patients and their relatives on an individual and family level and through regular family meetings.

Emotional support

- It was acknowledged that caring for the patients at RMC was physically and emotionally demanding. The psychology team were able to provide confidential psychological support to individual staff. The commitment to clinical supervision at RMC also enabled staff to receive emotional support in relation to their work.
- Staff were aware of the challenges of managing expectations of families and managing treatment for patients with long term conditions. Clinical staff in the focus group told us that sometimes patients, due to their diagnosis, could be unique and challenging but the staff had a sense of pride in providing good care. Support workers in the focus group told us they had a lot of patient and relative contact.

Are long term conditions responsive to people's needs?
(for example, to feedback?)

We looked at how responsive to people's needs the hospital was and found some services were delivered in a way that focussed only on medical and nursing needs. We found concerns regarding End Of Life Care (EOLC), advance care planning, and the recognition for emotional support and spiritual needs.

The provider understood the needs of the patients it served and designed services to meet those needs which included active engagement and commissioners, families and carers and other healthcare agencies. Patients received care and treatment in a timely way. There was a proactive approach to managing referrals, assessments, admissions and discharge from the service.

Patients and those close to them had the information they needed and were supported to provide feedback or to make a complaint. Complaints were taken seriously, investigated and resolved.

Service planning and delivery to meet the needs of local people

Long term conditions

- The RMC was actively involved in developing the Kent and Medway wide strategy for neuro-rehabilitation. This work closely reflected on the subsequent development of their services and the need to develop more acute level 1 and 2 rehabilitation services. Furthermore the RMC had developed close links to the relevant commissioning services and had frequent meetings to consider how the RMC can respond to the needs of the local population. The local NHS rehabilitation unit is due for closure in March 2016 and the provider is already in conversation with the relevant commissioners about how the RMC can support this gap.
- The RMC had one of the only two hydrotherapy pools dedicated for neurorehabilitation in the Kent and Medway area.
- The hospital told us that they ensure patients receive prompt diagnosis of any changes in their condition with an appropriate referral for service provision and treatment. The hospital had a private contract for the arrangement for collection and testing of blood tests and microbiology.
- The hospital told us it was in discussion with Kings College Hospital with a view to considering the facilitation of a spasticity service at RMC. If successful this would provide Kent with a service closer and more convenient to patients living in the Kent area. It would also benefit current patients whilst as an inpatient and also allow consistency of service following discharge into the locality.
- Preadmission assessment and goals for referred patients were agreed with the commissioners prior, upon and following admission. Regular review meetings were held to which commissioners were invited. In case of non-attendance detailed reports are submitted with recommendation for the services provided. The hospital told us that all information is provided to out of area CCGs and the hospital actively works in partnership to facilitate timely interventions if they are required. We saw examples of review meeting notes and reports to CCG's.

Access and flow

- At the time of inspection there were 30 patients in the main house, eight patients in SCU and nine patients in Tobias House.
- The hospital received 89 referrals for admission between July 2014 and June 2015. Sixty one of these patients had complex disabilities.
- There were arrangements to ensure that patients admitted to the RMC were suitable and could benefit from the service offered. The hospital showed us their Admission, Transfer and Discharge Guidelines which took into consideration the BSRM guidance to best practice for specialist nursing home care for people with complex neurological disability. It contained guidelines for admission, an example of an admission checklist with allocated timeframes, pre admission and admission algorithms, transfer and referral guidelines and discharge guidelines.
- When a new referral was received the admissions committee met to discuss the suitability of the patient based on the information received. If the referral was suitable a pre assessment of the patient was arranged with members of the MDT appropriate to the patient's individual needs. If the referral was appropriate for a RMC placement then working in partnership with the commissioner the admission process was started.
- The hospital told us that discharge planning was started upon a patient's admission. The hospital encourages and supports social reintegration from point of admission and throughout a patients stay.
- We saw the discharge plans and arrangements for one patient in Tobias House. They were being discharged home with a 24 hour day package of care. Ten support workers had been employed and trained at the hospital for the individual needs of the patient. Additionally we saw that home visits had been facilitated for trial periods to determine suitability for all.
- Prior to inspection the provider informed us they had 10 people on their waiting list for admission. The provider prioritised referrals for admission on the need of the patient and their current location.
- The hospital told us that due to their focused discharge planning a bed can be made available in a timely manner. The provider attempted to have an emergency bed available at any given time but this was not always possible given the demand for beds.

- The hospital was unable to perform diagnostic tests like scans and x rays. Patients had to be referred to the local hospital for these services.

Meeting people's individual needs

- We saw that patient's rooms were bright and airy and made to look like home environment rather than hospital and some reflected the resident's individuality. Windows looked onto gardens. However, we saw no evidence of multi-sensory lighting, fish tanks or bubble tubes to use in the sensory stimulation of patients with prolonged disorders of consciousness.
- The hospital told us that it recognised that some patients, as a result of their complex needs, may need long term care and they had a number of specific beds for this population. They told us they recognised that some patients may need palliative and end of life care. This did not mean rehabilitation processes were terminated and they ensured they were as actively involved in their care as those patients on an active rehabilitation pathway.
- The hospital showed us their policy for the care of the dying. This policy listed the 10 "the dying person's bill of rights" and was based on a philosophy of care. This guidance was first published in 1975 but is still widely used in hospices. The policy also described the accommodation of the religious needs of the dying and deceased patient in relation to individual religions.
- However, the care of the dying policy was not robust and did not consider the current, recommended standards by BSRM for advance care planning and EOLC or Royal College of Physicians guidelines. `
- We spoke to the nominated EOLC lead and asked them about management and planning for patients who were considered EOLC. They told us that the policy was sparse and they were aware that it did not follow national guidelines. Staff told us that palliative care was discussed but was not high on their agenda given that all residents had life long and degenerative conditions.
- The hospital told us that they did not have any patients who had made an advance decision to refuse treatment or an advance care plan in place that sets out their future preferences, at the time of inspection.
- Care plans showed little recognition for emotional support despite the fact that patients had suffered a catastrophic event. Care plans did not reflect patients spiritual and emotional needs or how these needs could inform care plans, risk assessments or care strategies. The patient's individual religious needs were not in evidence or acknowledged in care plans.
- The hospital had a one page document in the staff handbook which referred to an equal opportunities policy. This document was aimed at staff and the hospital was unable to provide information how they manage equality and diversity issues for patients.
- We saw the minutes of the monthly service user meetings held by the hospital. This was an opportunity for patients and their relatives to request specific individual social events.
- We saw that patients who were unable to communicate used non-verbal communication charts successfully. We did not see any evidence of electronic assistive technology such as eye gaze or switch access systems that would be appropriate use for these patients. However, the provider told us that this equipment was available and used by several patients.
- Relatives that wanted the use of private space were able to use the sitting rooms in both the main building and Tobias House.
- In some areas of the hospital access was limited for wheelchair users or those with reduced mobility. The fire exit from the physiotherapy room was not wheelchair accessible and the hydrotherapy pool had a deep step into it.
- The information boards in Tobias House did not contain any information for staff, patients or relatives about prolonged disorders of consciousness and complex issues.

Learning from complaints and concerns

- The hospitals formal complaints process was aligned to the Independent Sector Complaints Adjudication Service of which they were a member. This complaints

process had been formally agreed and endorsed by the Department of Health and conforms to NHS procedures. The individual responsible for overseeing the management of complaints at the location was the chief executive.

- The hospital told us that they have developed an 'open door' policy that enabled patients and relatives to freely air their problems and complaints with any member of staff but more importantly with members of the senior management team. The hospital told us that due to this process it was rare that a complaint ever reached their formal process as all concerns were dealt with amicably. The provider believed it is of vital importance that services should listen carefully to relatives and as such they empower their staff to take an active role in partnering with patients relatives.
- Prior to inspection the hospital told us that during the period July 2014 and June 2015 they had received 10 compliments and two complaints. These complaints were handled under their formal complaints procedure. They were responded to in a timely manner, the complainant was supported and an apology was given.
- Patients and their relatives were supplied with a copy of the hospitals complaints procedure upon admission. We spoke to patients and relatives who confirmed they had received this information and knew who to contact if they had concerns.
- An example was given by a relative of a patient who told us that they had reported to staff that their relative was lying too flat. This resulted in an action plan to retrain staff in the appropriate positioning of patients. The relative told us that since staff had received the training the incidence had not happened again.

Are long term conditions well-led?

We found some concerns regarding the arrangements for and quality of leadership at RMC. These concerns related to taking action on concerning items identified at committee meetings, risk management, auditing and leadership style.

Risks and issues identified were not sufficiently monitored or documented. For example some audits were being performed but the hospital was unable to show that the results of these were consistently acted upon or used to improve service. There was no formal risk register.

It was evident through interviews that the chief executive maintained control of every aspect of the hospital and was averse to delegating duties to the directors of departments although staff reported they felt supported by their managers.

The vision of the hospital was to develop and provide a rehabilitation medical hospital, based on the anthroposophical image of man which recognised man as being of body, soul and spirit. Staff understood this philosophy and was supportive of it.

The hospital had an active research portfolio with a national and international profile.

Vision and strategy for this this core service

- The hospital told us that their vision of RMC was to develop and provide a rehabilitation medical hospital, based on the anthroposophical image of man which recognised man as being of body, soul and spirit. By working in close co-operation with conventional medical facilities and the development and support of their personnel they believed they could bring about an improvement in the health of individuals. Additionally the RMC believed that each patient should be given the opportunity to improve irrespective of their original diagnosis. The chief executive told us that this vision can be obtained through expansion of the hospital and its services. Staff we spoke with were supportive of this approach and positive regarding its outcome.
- We asked the neuro-rehabilitation consultant what their vision for the service was. They explained they would like patients to be transferred out to community placements earlier which would enable RMC to accommodate more acute patients.

Governance, risk management and quality measurement for this core service

- The provider used an external independent assessor to assess the quality of aspects of the management of the hospital. The hospital had achieved the following accreditation scheme and initiative: ISO 9001, ISO 14001, ISO 18001 and Investor in People.

Long term conditions

- The hospital told us that they had a medical advisory committee (MAC), safeguarding committee, clinical governance committee, and health and safety committee.
- The MAC was chaired by the consultant psychiatrist and reported to the clinical governance committee. The outcomes of clinical governance meetings were shared with MAC.
- We found issues raised and discussed at clinical governance meetings were not sufficiently followed through. There was no individual responsibility for actions assigned and there was no update on the progress or efficacy of actions decided. The minutes were conversational in style and did not contain any action logs.
- We reviewed the clinical governance committee meetings minutes between February 2015 and November 2015. This review was completed in order to track the recording of the ownership and actions of the minutes. This highlighted that themes and issues were not carried forward or bought back to the committee to provide robust assurance. For example, in the February 2015 minutes item 7 reported a high number of cases of pseudomonas and E coli. The action proposed that a protocol for urinary infections including weekly urine analysis be written. The minutes from May 2015, September 2015 and November 2015 made no further mention of pseudomonas and E coli or if a protocol had been written or implemented.
- The health and safety officer completed a risk management report every three months that highlighted identified threats that could disrupt normal business operations within the organisation. The report listed the identified threats both human and non-human with actions taken. The completed report was submitted to the clinical governance committee.
- The hospital provided us with a copy of their risk management policy/ business continuity plan. This was completed January 2015 and states it was to be completed annually. The aim of the plan was to enable the hospital to assess the impact of adverse reactions on the organisation. Five threats were identified. However, the plan was not robust or succinct as it did not advise or instigate action plans for the threats identified.
- The hospital was not able to provide us with a formal risk register.
- We asked for specific risk assessments as required by HBN 00-09 section 3.116 for maintenance, cleaning and infection controls involvement. We were told there were no risk assessments of this nature. Therefore the provider was not complying with HBN 00-09.
- We asked for specific risk assessments regarding carpeted areas as per HBN 00.09 and also general risk assessments of the cleaning tasks. We were told that there were only general manual handling risk assessments and none for the carpeted areas or the cleaning tasks. The management of Health and Safety at Work regulations 1999 states: "3.-(1) Every employer shall make a suitable and sufficient assessment of – (a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; and (b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking". By having no suitable or sufficient risk assessments the provider was not complying with these regulations.
- Although we did see the implementation of monitoring processes and completion of medicine audits, we did not see evidence that the results of these were consistently acted upon or used to improve the service. For example, inconsistencies in stock checks of medicines quantities were not addressed and poorly functioning fridges were not replaced. Additionally, concerns raised by staff did not appear to be acted upon. For example, concerns regarding the lack of clinical pharmacy service had been reported by staff to senior management.
- We saw that risks assessments for medicines were not completed for patients. Risk assessments were referred to in the hospital's medicines policy but a copy of the risk assessment document was not included in the policy.
- A clinical audit obtained in August 2015 highlighted areas of concern regarding the cause of rising rates of infection. The hospital confirmed that the audit had not been presented to the clinical governance committee and they were unable to provide us with results or updates of any of the actions recommended.

Leadership and culture of service

- The hospital told us that it prided itself on their 'open door' policy whereby patients and their relatives were able to discuss their care and treatment, at any time, should they not be happy or pleased with their care and treatment.
- Staff we spoke with in the focus groups told us they felt supported by team leaders. Staff were encouraged to escalate complaints and concerns. Medical staff told us there was a zero tolerance of bullying at the hospital and they felt supported by the director.
- Staff told us that five members of the multidisciplinary team had been funded and given protected time to attend the Institute of Leadership and Management (ILM) courses.
- The structure of the management of the hospital consisted of a chief executive who was answerable to the board of directors. There were departmental directors for therapists, nursing, human resources and finance, medical and hotel services.
- The chief executive recognised that each area of the hospital required an accountable person and recruited ward managers in August 2015 to take this responsibility. People did not apply for the roles but were selected individually by the chief executive. There was no formal recruitment or selection process for these staff that ensured they had the skills knowledge and experience to undertake this role. However, the provider was confident that staff were selected on a meritorious basis.
- It was evident through interviews that the chief executive maintained control of every aspect of the hospital and was averse to delegating duties to the directors of departments. This resulted in a highly directive and controlling style of leadership. Two managers told us that their job descriptions had changed but they had been given limited extra responsibilities for these roles.
- From minutes of management meetings we noted that when problems were identified, often the response was to assign a responsibility to a staff group with the instruction to do better. There was little analytical discussion about the causes of those challenges or alternative ways of managing them. The clinical governance meeting in February 2015 discussed infection control and use of antibiotics. The chief executives response was for "nurses to understand better how to contain these infections and improve their practice regarding hygiene". Infection control is the responsibility of all and not just nurses.
- The hospital told us that they employed 105 full time equivalent health care assistants and 90 of these were on a full time contract. They had seven full time equivalent vacancies. In the previous 12 months 41 staff had left the service and 39 had been recruited. This demonstrated that the hospital had a high turnover of staff.

Public, patient and staff engagement

- The RMC had a bi-monthly family meeting. These encompassed peer support, feedback on services and an educational training programme. The hospital told us that this proved to be a vital part of the provider's service to all users and as such they have been requested to make these meetings monthly. Families were actively involved in choosing the topics for the meetings and this also included arranging trips out.
- The provider also held monthly patient meetings in the neurorehabilitation unit if appropriate with the patient mix at the time. When there were service changes they encouraged patients and families to express their thoughts about changing services, which could occur formally and informally.
- The hospital told us that they gather feedback from the people who use the services they provide. A patient satisfaction questionnaire was carried out to obtain feedback from patients and relatives on how they find the services they provide. The provider told us that they take all feedback seriously and will act on concerns and issues. They pride themselves on having an 'open door' policy. This meant that feedback from patients and families could be given at any time.
- We saw the results of the patient satisfaction questionnaire from October 2015. This was based on 23 returned questionnaires and the hospital acknowledged that this was not a true reflection of the services and facilities provided. Overall the survey was positive and an action plan was devised for staff to rectify negative comments. For example for staff to aim for 100% satisfaction to the question: "how clean is your room?" However the hospital did not provide us evidence of any results of the action plan devised.
- The questionnaire contained comments from patients requesting better stimulation when not receiving

treatments or therapies rather than being left alone in their rooms. Also requesting better communication between patients and therapists particularly regarding cancelled appointments.

- We saw the minutes of staff meetings held at the hospital.
- The hospital showed us the satisfaction questionnaire it provided for its employees in 2014. There were 41 questionnaires returned. Figures provided showed that 28 staff was satisfied with working for the company and all 41 responses would recommend the company as a good place to work. However we noted there was a discrepancy in the calculation in the figures as they did not add up correctly.

Innovation, improvement and sustainability

- The hospital confirmed that they had an active research portfolio which enabled them to audit outcome of therapies, medications and processes. They told us they had presented their findings in world conferences and had articles published which we saw.
- An article had been published in the journal “Brain Impairment” and two books had been written. This included the account of a survivor of brain damage. We were shown details of three current research projects that were in progress and relevant to their field of expertise.

Outstanding practice and areas for improvement

Outstanding practice

The hospital was involved in a number of national studies relating to the treatment of people with acquired brain injury. The hospital was instrumental in developing, piloting and refining the Wessex Head Injury Matrix (WHIM) used in auditing outcome in prolonged disorders of consciousness.

Areas for improvement

Action the provider MUST take to improve

- Ensure that it provides feedback to staff regarding safety incidents and consider systems to ensure that there is appropriate learning from such incidents.
- Ensure all fire exits are wheelchair accessible and are not blocked and provide appropriate fire exit signage.
- Consider who ensures that waste is segregated and stored to meet current guidance.
- Consider systems to ensure the safety and quality of the water supply throughout the premises and in the hydrotherapy pool.
- Develop systems to ensure medicines are stored at the manufacturers' recommended temperatures.
- Have systems that ensure that equipment shared between patients is decontaminated after use.
- Develop schedules, risk assessments and monitoring systems to ensure the adequacy of cleaning arrangements.
- Conduct risk assessments when floor covering materials do not meet published specifications and consider the appropriateness of soft furnishings and seat covering material.
- Consider the means of summoning emergency assistance in the art room.
- Ensure consultant staff have current practicing privileges in place.
- Have systems to ensure that all electrical equipment, including clinical equipment, is appropriately checked and maintained.
- Consider how it evaluates the effectiveness of care and benchmarks performance against other similar centres.
- Develop robust systems of governance, including risk registers and business continuity plans that mitigate identified risks.
- Make arrangements for the controlled drugs accountable officer role to be fulfilled according to guidance.
- Ensure all statutory notifications relating to safeguarding or Deprivation of Liberties Safeguards are reported to the CQC in a timely manner.

Action the provider SHOULD take to improve

- Consider how care plans reflect the spiritual and emotional needs of patients to guide staff in providing patient-centred care.
- Take action to ensure all goal setting meetings are documented.
- Take action that ensures patient records reflect the input of all health care staff retreating the patient, including therapy staff.
- Make arrangements to provide information for staff, patients or relatives about prolonged disorders of consciousness and complex issues in Tobias House.
- Consider how an early warning system such as the National Early Warning Score (NEWS) could be used in to comply with BSRM guidance.
- Make arrangements that ensure patients requiring replacement of artificial feeding tubes can be treated on-site at all times by staff with the required competency.
- Introduce systems to audit DNACPR documents and processes and can learn from these.
- Review its policy and staff training with respect to end of life care in order to meet current guidance and best practice. Consider how the use of advance care plans could be used to enable patients to express future preferences.
- Ensure that there are arrangements to maintain the dignity of patients in the therapy room.

Outstanding practice and areas for improvement

- Consider how management and leadership responsibilities and accountabilities can be delegated and shared by the senior management team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider was not notifying the CQC of all safeguarding incidents. This breached Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents part (1) 2) (e). The provider had not notified the CQC of requests made to a supervisory body for authorisation to deprive a patient of their liberty. This breached Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents part (1) (4A) 9 (a).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not demonstrating lessons learned from safety incidents. There were examples of breaches in fire safety regulations (Health Technical Memorandum 05-02). Waste management did not meet guidance (Health Technical Memorandum 07-01 section 5.11). The guidance contained in the "National Specification on Cleanliness" was not being met. Not all of the provisions of the "Code of Practice on the prevention and control of infections and related guidance" (DoH, 2015) or Health Building Note 00-09 section 3 were being met. The use and management of floor coverings did not comply with Health Technical Memorandum 07-01 sections 3.108, 3.109, 3.115 and 3.116. Medicines were not stored at appropriate temperatures. Water safety was not monitored according to guidance (Health Technical Memorandum 04-01). This breached Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment parts 12(1) (2) (b) (d) (g) (h).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The governance arrangements did not adequately monitor performance and risks or provide appropriate assurance to the board.

This section is primarily information for the provider

Enforcement actions

There insufficient systems to monitor the clinical outcomes for patients or to benchmark services.

Electrical equipment was not being checked appropriately.

Consultants did not have practicing privileges agreements.

The controlled drugs officer appointment did not meet current conditions for the role (Sec 4 The Controlled Drugs (Supervision of Management and Use) Regulations 2013).

This breached Regulation 17 HSCA (RA) Regulations 2014 Good governance part (1) (2) (a) (b).