Hunters Moor Neurorehabilitation Centre for the West Midlands - The Janet Barnes Unit

Quality Report

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Date of inspection visit: 7 and 8 March 2016
Date of publication: 15/07/2016

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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.

Overall summary

- We rated Janet Barnes unit as Good because
- Treatment was effectively organised to help maximise patient recovery and potential.
- Patients had access to good physical and psychological healthcare.
- There was effective team working to integrate physical, cognitive, and psychological recovery.
- There were sufficient staff to ensure patient safety.
- The service learned from past incidents and complaints to improve.
- Overall, staff were positive and encouraged patient recovery and well-being.
- Patients and relatives were involved in and informed of treatment and progress.
- Patients and relatives were able to raise any concerns or complaints and have them addressed.
- There was good medicine management.
- Patients' rights were safeguarded whilst on the unit.
- The unit was clean and well-maintained.
- Patients, relatives and staff were positive about the new manager, who they saw as approachable, involved and responsible for improvements in the running of the service. It was clear that, under the new manager, the service had made major improvements since the previous inspections.

However,

- Not all staff received regular supervision to help support them in carrying out their duties effectively.

Summary of findings

Contents

Good

Janet Barnes Unit

Services we looked at

Services for people with acquired brain injury.

Summary of this inspection

Background to Hunters Moor Neurorehabilitation Centre for the West Midlands - The Janet Barnes Unit

- Janet Barnes unit is an independent hospital for people who have an acquired brain injury and need rehabilitation. It is registered for 35 beds. On inspection the unit was catering for up to 26 patients. The main unit downstairs has beds for up to 15 patients. Upstairs, the community re-integration unit (cru) has provision for 11 patients. During our visit, there were 14 patients on the main Janet Barnes unit and 9 patients on the Community Re-integration unit.
- The unit is adjacent to Olive Carter unit, which also caters for people with acquired brain injuries. Olive Carter unit caters for people whose behaviours may be more challenging and may be subject to the Mental Health Act. Both units are run by the same organisation.
- The unit is registered to carry out the following regulated activities;

Diagnostic & screening procedures,

Personal care,

The treatment of disease, disorder or injury.

- Janet Barnes unit is registered with CQC as a hospital. It does not carry out diagnostic & screening procedures and does not have the facilities to do so. The unit is currently looking at options to re-register as a nursing home.
- The unit had a new manager in place who, at the time of our visit, told us his application to register as manager was being forwarded to CQC. It had not, at the time of this inspection, been received by CQC.
- The unit had been previously inspected on the 5, 6 and 14 March 2014 where action was needed in the following areas: co-operating with other providers; management of medicines; assessing and monitoring the quality of the service provision and records.
- A follow up, responsive inspection on the 24 and 30 September 2015 identified shortfalls in medication management, care records and staff supervision.

Our inspection team

Team leader: Martin Brown

The team that inspected the service comprised three CQC inspectors, a CQC analyst and a CQC pharmacy inspector.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

During the inspection, the inspection team:

Summary of this inspection

- toured the unit, looked at the quality of the environment and observed how staff were caring for patients,
- spoke with 17 patients who were using the service, five of them at length,
- spoke with three carers/relatives of patients, and had contact with one further relative after the inspection,
- spoke with the manager of the service,
- spoke with 15 other staff members; including clinicians, nurses and rehabilitation assistants,
- attended and observed a hand-over meeting, a review meeting and a multi-disciplinary meeting,
- looked at six patient care and treatment records,
- carried out a specific check of the medication management, and
- reviewed a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients and relatives were very positive about the service. They were particularly impressed with the progress individual patients made on the unit and the effectiveness of treatment. One relative compared the treatment and progress at Janet Barnes very favourably with that experienced at other hospitals.

They were equally impressed with the new manager. One relative told us they had previously found it difficult to get information from the unit, but that this had changed for the better with the new manager. Several patients and relatives said the manager and the staff were approachable. There was particular praise for the support and positive approach of the clinical and therapeutic staff. There was also praise for the cleaning staff for keeping the unit clean and tidy, and for also for listening and being supportive on occasions.

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?

Good

We rated safe as **good** because

- The unit was clean, and furnished and maintained to a high standard.
- Call bells and alarms were in place and staff responded promptly.
- There were sufficient staff on duty to ensure patients were safely monitored and supported.
- Staff were trained to use effective de-escalation techniques to help keep patients calm and safe.
- There was sufficient medical cover to keep patients safe.
- Patients had risk assessments that the service completed upon admission and updated in a timely manner. The service used recognised monitoring tools to ensure patients were safely cared for.
- The service applied for Deprivation of Liberty Safeguards as appropriate. This helped ensure that the service protected patients without unduly restricting their liberties.
- Staff used clear observation protocols to keep patients assessed as at risk safe.
- The service was diligent and transparent in raising safeguarding concerns.
- There was good, safe management of medicines.
- The service learned from past mistakes in order to improve the service.

However,

- It was not clear whether rehabilitation assistants benefitted from sharing in any learning from incidents or mistakes.
- It was not clear if all portable appliance testing was up to date, as details on some stickers were illegible.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- While clinicians received regular professional supervision, unqualified care staff received infrequent or no supervision.
- While clinicians were positive about training and were able to access relevant specialist training, rehabilitation assistants were less positive about training, particularly the lack of specialist training to meet the specific care needs of patients.

However,

Summary of this inspection

- Patients had good access to physical healthcare. Physical health checks took place regularly.
- Recognised monitoring and assessment tools were used to chart and support patient recovery.
- Care records were up to date, and guided and reflected good care and treatment.
- Medicines management was effective and supported treatment and patient well-being.
- Treatment followed recognised guidelines and was supported by monitoring tools to ensure optimal outcomes. Physiotherapy and occupational therapy interventions were employed to maximise patient recovery. Psychology support maximised cognitive recovery.
- A good mix of staff skilled in various disciplines worked together to help patient recovery.
- The service liaised with local agencies over safeguarding issues.
- Multi-disciplinary meetings demonstrated the effectiveness of team working. They showed teams being patient focussed and working together to improve patient recovery and well-being.
- The service considered consent and capacity issues, with best interests meetings and Deprivation of Liberty Safeguard applications in place where appropriate.

Are services caring?

Good

- Overall, staff were very positive and encouraging towards patients, helping them maximise their recovery potential.
- Patients and carers were very positive in their views of staff. They were particularly impressed by the progress patients made with the support of clinicians and therapists.
- Clinical staff and nurses showed a good understanding of the individual needs of patients.
- Patients were involved in their care and treatment, principally by discussion with clinicians and therapists. Patients and relatives showed a good awareness of treatment plans.

However,

- We observed two rehabilitation assistants moving a patient while making very little verbal or other interaction with them.

Are services responsive?

Good

We rated responsive as good because;

- Patients were able to remain at the unit for sufficient time to enable effective treatment and recovery. This was monitored to meet individual need.
- Discharge was rarely delayed for non-medical reasons.

Summary of this inspection

- The unit had a suitable range of rooms and facilities to support treatment and care.
- Patients could personalise rooms, had safe storage for possessions and had access, with staff support if required to hot drinks and snacks at any time.
- There were facilities to meet with relatives and other visitors.
- Therapeutic and treatment activities were an integral part of each patient's individual recovery plan and took place regularly, in accordance with individual patient plans.
- Information about the service was freely available for patients and carers.
- Patients and carers were able to raise concerns and complaints. The service responded to complaints and took action where complaints showed shortfalls.

However,

- Although there was a mini-bus to facilitate patient activities and appointments, this was rarely used, owing to a shortage of drivers.

Are services well-led?

Good

We rated well-led as good because:

- Staff, patients and relatives were very positive about the new manager, who had been in post for six months. People we spoke with said he was approachable and supportive. We noticed considerable improvements in the service, particularly in areas that were previously non-compliant.
- Staff, patients and relatives were very positive about the new manager, who had been in post for six months. People we spoke with said he was approachable and supportive. We noticed considerable improvements in the service, particularly in areas that were previously non-compliant.
- Systems were much improved. For example, the unit had greatly improved medicines management, with clear recording and checking. Care records were clearer and more accessible.
- There was good teamwork, particularly amongst clinical and therapy teams. This all helped support patient recovery.
- Although there was still room for improvement, staff training was taking place more regularly, with more staff now receiving training.

However,

- Supervision amongst unqualified rehabilitation staff was irregular. A number of rehab staff did not appear to be engaged with the service and its aims. Management were putting plans in place to address this.

Summary of this inspection

- There was no evidence of a survey of staff at Janet Barnes unit.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw records of the last 3 months Deprivation of Liberty Safeguard (DoLS) applications. These showed applications were linked to consent issues and capacity assessments. They reflected the manager's statement that 90% of current patients had DoLS in place or applied for.
- We saw that capacity and consent for individual patients were clearly recorded on a specific DoLS spreadsheet. This included brief relevant comments concerning individual capacity and consent.
- The service supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We discussed examples with staff and saw that capacity issues were properly considered and best interest meetings took place where required.
- A service co-ordinator based at the unit was able to offer advice regarding the Mental Capacity Act (MCA), including DoLS.
- The service co-ordinator monitored adherence to the MCA. We saw records that monitored consent, capacity and DOLs applications on a patient-by-patient basis.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Good	Requires improvement	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Good	Good	Good

Good

Services for people with acquired brain injury

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good

Are services for people with acquired brain injury safe?

Good

Safe and clean environment

- Communal areas were open and uncluttered so they could be overseen by staff. All bedrooms and therapy rooms had windows with internal blinds that allowed staff to observe when required, but also allowed patients privacy and dignity.
- The service undertook environmental risk assessments, including ligature risks. These took account of the specific needs of patients admitted to the unit. The service would not admit any patient identified as a suicide risk. Such a patient would go to the adjacent Olive Carter unit.
- The unit was not gender segregated. All rooms had en-suite facilities, including showers. Patients on Janet Barnes unit were not mobile without assistance.
- There was a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. Staff checked these regularly.
- All ward areas were clean, and had well maintained furnishings. Staff and patients told us furnishings had improved over the past six months.
- There was no seclusion room, as the service did not use seclusion.
- Staff adhered to infection control principles including handwashing. The most recent (December 2014) food hygiene rating of the unit by the local authority was the maximum, five.
- We spoke with the person responsible for maintenance of equipment who satisfactorily explained the processes for ensuring all equipment such as hoists and wheelchairs had regular safety checks. Maintenance records of checks and actions were available. There were visible and in date maintenance stickers. However, on electrical equipment some of the PAT stickers were not clearly legible. Some were out of date indicating equipment needed retesting.
- Cleaning records were up to date and signed. These showed regular cleaning took place. Patients and carers told us the domestic staff kept the unit clean.
- There were up to date temperature charts for fridge and clinic room temperatures. These showed that medicines were kept at safe temperatures.
- Alarms and call systems were in place. We saw these met the needs of individual patients. For example, one patient with very limited mobility had an alarm they could activate by brushing their hand or arm against it. We saw staff responding promptly to calls throughout our visit. Alarm systems clearly identified which room a call was made from.

Safe staffing

- There were a minimum of two nurses on duty during the day shift, supported by a minimum of six rehabilitation assistants. This was in accordance with agreed staffing of one nurse per eight patients and one rehabilitation assistant per three patients. During our visit, there were an extra three rehabilitation assistants. This was because the unit had assessed three patients as needing one to one support. Agency staff were used to maintain these ratios when required. On the community reintegration unit, there were six rehabilitation assistants and one nurse.

Good

Services for people with acquired brain injury

- The number of nurses required by the unit was seven. The unit currently had four nurses, with three nurse vacancies. This meant a high use of agency nurses to ensure there were sufficient numbers of nurses on each shift. There were two regular agency nurses used. The manager advised the unit had just appointed another nurse who was due to start that month. They were to interview another nurse. Senior staff told us of a recent recruitment drive to recruit additional permanent staff.
- There were three rehabilitation assistant vacancies. The full complement was 32 rehabilitation assistants. The unit used agency rehabilitation assistants to fill the shortfall. They also helped provide additional cover where individual patients required one to one observation/support.
- There were additional staff on duty to ensure patients who required regular observations and support were safely monitored and supported. We saw examples of this where patients required close monitoring. This was because of the risk of them falling when they did not fully understand the impact of their impaired balance and mobility. Staff accompanied them discreetly to help keep them safe.
- Wherever possible, the service used agency staff who were familiar with the unit. Agency staff we spoke with worked regularly on the ward and had done so for several months. One agency staff told us how staff had helped them become familiar with the service during their first shifts there: "The permanent staff all know the clients really well. The senior explained them all to me. Everything is there in the files."
- A qualified nurse was present in communal areas of the unit at all times. Feedback from patients we spoke with indicated that staff were present and attentive. When a patient accidently pressed the call bell, a member of staff promptly appeared to check all was well.
- There was no evidence of ward activities being cancelled more than very occasionally because there were too few staff. Patients and staff told us consistently therapy sessions took place as planned. One patient told us that a recent occupational therapy session had been cancelled at short notice, and they were unaware why. This appeared an exception.
- There were no physical restraints carried out. The unit deployed sufficient staff to carry out de-escalation when needed. Patients and carers spoke positively of staff calming patients if they became agitated. In a multi-disciplinary meeting, we witnessed careful discussion on how to improve aspects of a patient's health, without jeopardising their much-improved behaviour. All patients we spoke with said they felt safe on the unit.
- The consultants employed by the service provided medical cover on Tuesdays and Thursdays. An agency GP service provided an on-site presence for set times on the other three weekdays, and there was an on-call service at all other times.
- Initial data returned by the service showed low levels of mandatory training, but this had improved by the time of our visit. Staff consistently told us there had been a lot of training taking place in the past month. Areas still below 75% were refresher training in safeguarding (e-learning) (55%) and food hygiene (e-learning) (66%). We were confident that the service was now ensuring that staff were undertaking refresher training to achieve at least 75% attainment. The manager acknowledged the need to monitor refresher training so that it took place in a timely manner.

Assessing and managing risk to patients and staff

- We saw up-to-date risk assessments were present in the sample of six care plans we looked at. Clinicians and senior staff were consistently able to explain how this was undertaken. They explained what tools they used to assess risk as part of overall assessments and monitoring of recovery. These included assessment tools such as the Waterlow pressure ulcer risk assessment and the Modified Early Warning Score, which help identify potential risks so that timely interventions can take place.
- We found no evidence of any blanket restrictions. There were notices by exit doors advising informal patients that they could leave, but asking them to contact a suitable member of staff to discuss any safety concerns first. There were clear observation protocols in place to manage and minimise individual assessed risks. Where risk was assessed, additional staff were employed to provide one to one observation and support to ensure patients were safe and not a risk to themselves or other patients.
- Staff were trained in Non-Abusive Psychological or Physical Intervention (NAPPI). Staff consistently told us they used de-escalation rather than restraint. There were no incidents of restraint on Janet Barnes unit. Staff were able to give examples of the use of de-escalation.

Records, discussion with staff and carers confirmed the success this approach, had with particular patients. There was no use of either rapid tranquilisation or seclusion on Janet Barnes unit.

- All qualified staff and clinicians were clear on how to raise safeguarding alerts. Staff gave examples of safeguarding alerts. These included internal safeguarding, such as medication issues, or external issues such as concerns about the motives and involvement of particular outside persons with patients. There had been 16 safeguarding alerts or concerns raised in the year from October 2014 to October 2015. The manager showed transparency and diligence in ensuring Janet Barnes unit raised safeguarding concerns with the local authority safeguarding team.
- There was good safe medicines management practice. Controlled drugs that required separate secure storage arrangements were stored securely in dedicated controlled drug cupboards. Medicines were stored within the recommended temperature ranges for safe medicine storage. Daily temperature records showed that temperatures for the medicine refrigerator and the medicine room were within acceptable limits. The service had recently received support from a specialist clinical pharmacist. They had provided advice on ensuring the service managed medicines safely. They had also undertaken checks on medicines stored by the service. Supporting information for staff to administer medicines safely was available and easily accessible. Daily medicine checks were undertaken which ensured consistent standards were maintained. The service dealt with medicine errors promptly in order to learn and prevent the error happening again. There was an open culture of reporting medicine problems.
- Staff were aware of and addressed any outlier issues such as falls or pressure ulcers. Staff filled in body charts and reported any issues of concern to senior staff for investigation. The majority of additional staff deployed for ones to one observations with individual patients were required in order to ensure patients at risk from falling were kept safe.
- There were safe arrangements for children that visited the ward. The service had allocated the sensory room as a children's space when people with children visited patients.

Track record on safety

- There were no serious incidents recorded in the past twelve months.
- The service reported medication errors and raised them as safeguarding alerts where appropriate.
- We saw examples of how medication errors had informed improvements in the management and administration of medication.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents they should report and how to report them. Staff told us had forms to fill in that helped make it easier for them to report any incidents. Reporting of adverse incidents helped by staff helped clinicians become aware of when treatments had not gone to plan and had to be modified. A clinician gave an example of when things had not worked out as well as anticipated. A patient had transferred from the adjacent Olive Carter unit to the community re-integration unit. The transfer was not conducted at a pace to meet the patient's needs and their challenging behaviour escalated. The service learnt from this and ensured future transfers took place at a pace completely in accord with each patient's needs, with better and clearer verbal liaison between the two units.
- Patients and carers we spoke with all said staff and management were approachable and explained things to them. Patients and carers we spoke with could not think of things that had gone wrong. The only example was of a cancelled session. The patient said they were not aware of the reason for the cancellation. We observed a staff member informing a patient and carer of progress with medical appointments and explaining that there had been a problem in getting a particular aid. They then explained what they were doing to address this.
- We saw evidence of clinicians learning from mistakes. These tended to be regarding the effectiveness of treatments, rather than incidents. For example, one clinician acknowledged that in setting one particular patient tasks related to their therapy, they had underestimated the patient's anxiety when confronted with new tasks. This had resulted in a slowing of this patient's progress and a reassessment of tasks. The clinicians had learned from this and shared the lessons at the next multi-disciplinary meeting.
- Multi-disciplinary meetings discussed instances where treatments and approaches were not proving as

Good

Services for people with acquired brain injury

effective as they might have been. The team discussed possible improvements. This appeared to happen primarily with clinicians and nurses. We saw less evidence of this happening with rehab assistants. Two of the rehab assistants we spoke with felt they did not get told when things went wrong so they could learn from them.

- Some staff reported difficulties in supporting one particular patient. Management were aware of this and were working to resolve this and to support staff.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at six care records. Comprehensive and timely assessments were completed after admission. When a patient arrived, the unit received a summary from their previous placement. Clinicians undertook a clinical assessment to assess needs, and in addition, therapy teams undertook therapy assessments in order to plan what therapy was required to maximise rehabilitation.
- The care plans we looked at were holistic, giving a rounded picture of patients' needs and wishes. They were recovery orientated, showing what patients' goals were. Care records showed that physical examinations were undertaken and that there was ongoing monitoring of physical health problems. There was good access to physical healthcare; including access to specialists when needed. We saw regular attention to physical healthcare. Patients were weighed regularly. Assessment and outcome tools such as Waterlow pressure ulcer risk assessments and the Modified Early Warning Score were used to ensure physical well-being. Hydration and nutrition was monitored in accordance with assessed risks.
- All information needed to deliver care was stored securely in paper files. It was available to staff when they needed it and in an accessible form; including when people moved between teams. One agency staff we spoke with told us they felt the files were accessible and useful for obtaining information.

Best practice in treatment and care

- We looked at eight people's Medicine Administration Record (MAR) charts. We found that the arrangements for medicine management were person centred at all stages and followed National Institute for Health and Care Excellence (NICE) guidelines. Patients' medicines were available to treat their diagnosed health conditions. MAR charts accurately recorded the giving of prescribed medicines. There were accurate medicine stock checks. This meant it was possible to check the balance of all medicines to ensure they had been given as prescribed. We found that all the balances we checked were accurate. We saw detailed information on how people preferred to be given their medicines. This was helpful for nurses who might not be familiar with a person's specific needs. There was clear documentation for the site of medicine patch applications on a person's body. This is particularly important for pain relief medicines. We spoke with two regular agency nurses who both agreed that the detailed information was very helpful for giving people their medicines. Arrangements were in place to ensure that medicines required by patients at specific times were clearly highlighted on the MAR charts with reminders also displayed. We observed one nurse correctly administering a medicine that a patient required at a specific time. When people were prescribed a medicine to be given 'when required' for agitation we found that supporting information was available to enable staff to make a decision as to when to give the medicine. However, we found that it would be helpful to make more detailed information available, particularly for medicines prescribed for agitation or anxiety. Patient's medicines were labelled individually and kept secured in locked medicine trolleys. The nurse in charge held the keys for medicine storage.
- The service offered psychological therapies recommended by the National Institute for Health and Care Excellence (NICE). Cognitive behavioural therapy engaged patients in gaining insight into their condition. This helped them regain and develop cognitive skills. Measuring tools such as the Hospital Anxiety Depression Scale were used to help monitor patients well-being.
- Each patient had regular therapy sessions. Psychology, occupational therapy and physiotherapy teams all worked together to help patients recover. Daily orientation programmes helped individual patients to improve memory and cognitive skills. These included

doing 'word search' and other puzzles with patients, and reading and discussing the news. We saw current newspapers freely available. Patients and carers were very positive in their comments about the therapy offered, and the improvements it had produced. We saw examples of patients coming to the unit unable to move independently, and starting to walk during their stay. One carer told us how the patient they were concerned about had made little progress in previous hospital settings, but was now making progress in all areas.

- The service used recognised rating scales to assess and record severity of need and progress and outcomes. In addition to such tools as Waterlow pressure ulcer risk assessment tool and the Modified Early warning Score, specific rehabilitation tools such Goal Assessment Scales, Functional Assessment Measures were used to chart individual progress. The UK Rehabilitation Outcome Collaborative (UKROC) measuring tool helped gauge that the unit was treating people in the most safe, effective manner. The Hospital Anxiety and Depression Scale (HADS) was used by clinicians to help determine how well being impacted on recovery in order to assist effective treatment.
- Clinical staff undertook audits of clinical notes, infection control measures and medication.

Skilled staff to deliver care

- There was a good range of mental health disciplines and workers on the unit. In addition to nursing and rehabilitation support staff, there were occupational therapists, physiotherapists, and psychologists. The service also had access, by contract, to a dietician, and a speech and language therapist. The dietician felt their contract, which offered one day a week support to the unit, was not a good use of resources. The manager agreed and informed us this was to be re-negotiated and a permanent dietician sought for the unit.
- The consultant we spoke with had worked on the unit since it opened. Other clinicians were experienced, qualified, enthusiastic and motivated. All had appropriate qualifications.
- Induction records showed new staff received appropriate induction, including undertaking the Care Certificate where appropriate. We spoke with one new member of staff who detailed their induction. They had a three-day induction prior to coming to the unit and since then had been working and undertaking further training as part of a probationary period.
- Clinicians and therapists all spoke of receiving regular professional supervision and appraisals. Assistant psychologists, for example, received weekly supervision. This was not happening with unqualified staff. There was no clear evidence of supervision and appraisals presented by the unit. One rehabilitation assistant told us they had recently had their first supervision for over a year. They had yearly appraisals, and thought the supervisions were part of the appraisals. The manager acknowledged that supervision was an area that the service needed to address. There were indications that the service was starting to address the issue, as some staff noted they had recently had, or were about to have, supervision.
- Clinical and therapy staff were very positive about their training and were able to detail a variety of training they had undertaken. As well as initial training, clinicians had refresher training and were able to 'make a case' for additional training related to their specialisms. Rehabilitation assistants were less positive about their training. Some rehabilitation assistants said they did not receive specialist training, such as catheter care, or that it was on-line. Initial data returned by the service showed low levels of mandatory training, but this had improved by the time of our visit. Staff consistently told us there had been a lot of training taking place in the past month. Revised figures we received immediately following the inspection showed training including unqualified staff was within acceptable levels of 75%. The manager agreed the service need to have clearer systems to monitor staff training and ensure adherence to training to ensure the service had a fully trained staff team.

- The service addressed poor staff performance promptly and effectively. We discussed an example that had resulted in a suspension and possible further action. The service had acted promptly in addressing this and had suspended four staff members. After investigation, three had been re-instated, but the fourth was still under investigation.

Multi-disciplinary and inter-agency team work

Good

Services for people with acquired brain injury

- There were weekly multi-disciplinary meetings. We attended one and saw that it was patient and recovery focused. There were contributions by all attendees, including therapists, psychologists, nurses, a consultant psychiatrist and the manager. However, there was no attendance or involvement of rehabilitation assistants. One rehabilitation assistant told us they would like to take part in them as they could learn from them. They also felt they could contribute to them as they had close daily contact with the patients.
- We attended one of the daily handovers. It was patient and recovery focused, passing on information relevant to an individual patient's well-being and recovery.
- We saw evidence of clinicians learning from mistakes. These tended to be regarding the effectiveness of treatments, rather than incidents. For example, one clinician acknowledged that in setting one particular patient tasks related to their therapy, they had underestimated the patient's anxiety when confronted with new tasks. This had resulted in a slowing of this patient's progress and a reassessment of tasks. The clinicians had learned from this and shared the lessons at the next multi-disciplinary meeting.
- The service liaised with local authority safeguarding teams about safeguarding concerns. There had been issues with the relations with local GPs regarding responsibility for attending to patients. This had been resolved by employing a GP service to provide a regular service to patients when the unit's own doctors were not available.

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

- There were no detained patients on Janet Barnes unit. The manager was clear that the unit would not receive patients detained under the Mental Health Act. At the time of our visit, there was one patient on Janet Barnes unit receiving medication for mental health issues. This patient was previously on the adjacent Olive Carter unit. They had moved to Janet Barnes unit as part of their rehabilitation. A consultant based at Olive Carter unit monitored their medication. The manager advised us that if a patient's behaviour gave rise to concerns that they may need detaining under the Mental Health Act, they would move to the Olive Carter unit.
- Staff received training in the Mental Health Act. The manager gave us details of forthcoming training in this.

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Good practice in applying the Mental Capacity Act

- We saw records of Deprivation of Liberty Safeguard (DoLS) applications. These showed applications were clearly linked to consent issues and capacity assessments and reflected the manager's statement that 90% of current patients had DoLS in place or applied for.
- We saw that capacity and consent for individual patients was clearly recorded on a specific DoLS spreadsheet. This included brief relevant comments concerning individual capacity and consent.
- The service supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We discussed examples with staff and saw that capacity issues were properly considered and best interest meetings took place where required.
- A service co-ordinator based at the unit was able to offer advice regarding the Mental Capacity Act (MCA), including DoLS.
- Staff received training in the Mental Capacity Act and DoLS. The manager gave us details of forthcoming training in this.
- The service co-ordinator monitored adherence to the MCA. We saw records monitored consent, capacity and DOLs applications on a patient-by-patient basis.

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support..

- We observed staff behaving respectfully and discreetly towards patients. We saw some excellent examples of clinicians and nursing staff being encouraging, supportive and positive towards individual patients. We saw how this had a very positive effect on one patient's well-being. We observed two rehabilitation assistants moving a patient while making very little verbal or other interaction with them.
- Overall, we had positive reports from patients and carers about the staff. Clinical and therapy staff were

Good

Services for people with acquired brain injury

particularly praised. What patients and carers were most impressed by was the progress made by patients whilst they were on the unit. This came over consistently from carers and patients we spoke with. They praised the treatment and the approach and teamwork by staff that helped make the treatment effective. One relative made a distinction between the approach of clinicians, nurses and senior rehabilitation personnel, who they regarded as consistently excellent in their approach, and some of the rehabilitation assistants who they felt were less able to interact spontaneously. Patients and carers also praised cleaning staff, not only for doing a good job cleaning, but also for being another person to listen and understand.

- Staff, particularly clinical staff, showed a good understanding of the individual needs of patients. This was evident in multi-disciplinary teams, handovers, our discussions with staff, and in observing interactions with patients.

The involvement of people in the care they receive

- The admission process informed and oriented the patient to the ward and the service. One patient we spoke with described how the admission process helped them settle on the ward and find out what they needed to know.
- We did not see evidence of patients having copies of their care plans. However, we saw staff engage with patients about their treatment and wishes. Patients were present at review meetings. Here, their views were sought and listened to as part of the discussion of their treatment and recovery. At multi-disciplinary meetings, discussion included consideration of individual patient views. Therapy sessions encouraged active patient involvement. The aim of many sessions, as well as physical recovery, was to enhance patients' understanding of their condition and treatment in order to enhance well-being and progress. We observed discussion between a nurse, patients and relatives that demonstrated the service was keeping them informed with news of treatments and plans. This included arrangements for further treatment by external agencies and encouragement to maintain independence.
- Relatives we spoke consistently told us they were involved in treatment decisions. One patient told us how they were aware of their treatment plan and were fully in agreement with it: "I will do it to get better." One relative told us they had found it very difficult to get information from the service 'for many months' but that this had greatly improved since the arrival of the new manager. They said staff had also become much more approachable and communicative, and they hoped this change would continue.
- There was information available regarding advocacy services. Nearly all patients had relatives or other carers supporting them. One patient had no immediate family or carer support. The service was actively supporting this patient to access advocacy support by contacting the advocacy service.
- We asked for evidence of the most recent survey and received a copy of a staff patient and relative survey of 2014. This related to the organisation nationally, rather than the Janet Barnes unit specifically. One relative told us they had received questionnaires, but had neglected to complete them. The community re-integration unit had regular monthly community meetings where they could raise issues. They also had daily meetings. We attended one of these. This mainly involved planning for the day, but allowed patients to have their say regarding plans and any issues that arose from them.
- Patients were able to make advance decisions. We saw an example where one patient had made a specific advance decision. The service supported them in making this decision, ensuring it was in the patient's best interests. The reasons and the decision making process for this were clearly documented.

Are services for people with acquired brain injury responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy from July to December 2015 was 84%. Patients always had access to a bed when they returned from leave. Where patients required an extended stay in hospital, the service negotiated with the funding agency about funding to keep the bed available. The service used the UK ROC (Rehabilitation Outcomes Collaborative) monitoring tool, which

supported them and patients in helping ensure patient stay optimised their recovery. This tool helped the service determine the most appropriate lengths of stay for patients to support effective discharge.
- Janet Barnes unit admitted most patients from Birmingham and the Midlands area, and occasionally further afield.
- The service worked with patients and other agencies to plan discharges in a timely manner.
- If a patient presented challenges that could not be met within Janet Barnes unit, they could be transferred to the adjacent but separately registered Olive Carter unit. Similarly, a patient might move from Olive Carter unit to Janet Barnes unit if their needs changed or as part of their rehabilitation process.
- The service had access to a GP service that provided an on-call service at weekends and evenings and attended the unit three days a week. The other two days the consultants were present at the hospital.
- Individual patient needs were often so specialised that it was difficult to find a suitable placement offering the appropriate level of care. This was the main cause of delayed discharges. The service had reported four delayed discharges in the six months between July and December 2015. The service made us aware of three patients who were ready to discharge, for whom the service could do no more for in terms of treatment. For two of these patients commissioners were having difficulties identifying suitable places. One patient was reluctant to move, although the service had identified a suitable place. The service was working with other agencies and the patient to move them to a more suitable alternative care setting.

The facilities promote recovery, comfort and dignity and confidentiality

- There was a full range of rooms and equipment to support treatment and care. There was a well-equipped clinic room. Therapy rooms were in a separate corridor, enabling individual treatment and therapy to take place in a quiet and private area.
- Although there were no specific quiet rooms, there were day lounges as well as individual bedrooms, where patients could meet with families and others. Rooms were spacious because of the mobility aids required by most patients.
- Patients could make phone calls in private.
- There were tidy gardens and a smoking area for use by patients.
- Most patients we spoke with were positive about the food. One patient had expressed unhappiness with the choices made available to meet their particular preferences. Discussions with staff and patients, and past records showed that the kitchen staff were responsive to requests for changes to food.
- People could make hot drinks and snacks at any time. Where they were physically unable to do so safely, staff would assist them.
- Patients were able to personalise bedrooms. We saw that many had done so to make them quite individual.
- All patients had secure lockable storage space for possessions.
- There were agreed physiotherapy, occupational therapy and psychology activities as part of each patient's recovery plan. These took place regularly on weekdays and made a full day for most patients. We did not see much evidence of activities outside of this admittedly busy timetable. One patient said they would like to see more art activities. A music therapy class had recently started and some patients enjoyed this. We had reports of two patients particularly enjoying this. The patients on the community reintegration unit benefited from a wider range of community and social activities. We saw people escorted to go out on chosen social activities.
- There was a minibus to help take patients out more frequently, whether to appointments or to social activities. However, staff told us there was no dedicated driver, and that few staff were able to drive it, so it was rarely used at present.

Meeting the needs of all people who use the service

- The unit was designed to meet the needs of patients with high mobility support needs, with rooms and other facilities being large enough to allow for wheelchairs and hoists. There were adaptations made to meet individual needs. There were mobile hoists and tracking hoists where needed. However, corridors were not wide enough to allow for passing space for two wheelchair users.
- There was a wide variety of relevant information available. There was accessible information on treatments, local services, patients' rights, and on how to complain.
- The service said it could make interpreters and/or signers available if required. Similarly, information

Good

Services for people with acquired brain injury

leaflets were in English but it could make them available in other languages if required. Information was available in easy read formats for patients who would benefit from this.

- There was a choice of food to meet dietary requirements of religious and ethnic groups. The service supplied this, although one patient and their relative said they sometimes had difficulty in obtaining foods they wished for to meet their own particular dietary preference.
- The service said it could provide appropriate spiritual support, although patients or relatives did not raise this as an issue during our visit.
- Carers and patients told us they knew how to complain and were confident of doing so if they needed to. Carers and patients gave examples of issues they had raised informally to get resolved. There was information readily available on how to complain.

Listening to and learning from complaints

- There was a clear complaints policy. Staff were clear on how to respond to complaints. There had been six formal complaints received between January and September 2015. The service had responded to these and either partially or fully upheld them. There were no specific themes to these complaints. One concerned staffing levels, another meal options, and one wifi problems These had resulted in changes and improvements in service delivery. This showed the service was responsive to complaints. We saw compliments from patients and carers who had used the service.

Are services for people with acquired brain injury well-led?

Good

Vision and values

- The service aim was to rehabilitate patients by "Unlocking potential." The manager was clear on this and the approach of all senior, clinical and nursing staff was clearly in accordance with this. It was not clear whether all rehabilitation assistants, particularly agency workers, were fully aware of this aim.
- Clinical staff were aware of senior staff in the organisation. Senior staff had visited the unit. Staff and patients were positive about the manager. They said he was approachable and present on the unit.

Good governance

- Initial data returned by the service showed low levels of mandatory training, but this had improved by the time of our visit. Staff consistently told us there had been a lot of training taking place in the past month. Revised figures we received immediately following the inspection showed training was within acceptable levels.
- Supervision had not been taking place regularly. Clinical staff were positive about supervision, telling us they received regular clinical supervision. Rehabilitation assistants, who were not receiving regular supervision, appeared far less engaged with the service and its aims than did clinical staff. The manager recognised this and had put in place plans to improve supervision levels. A senior rehabilitation assistant told us they had begun to schedule supervisions for rehabilitation assistants.
- There was a sufficient number of staff of the right grades and experience to cover shifts. The service used agency staff to ensure one to one observations were in place and that there was sufficient nurse cover on all shifts.
- Medication management had improved. The service had learned from errors and reduced them.
- The service learnt from complaints, improving the service as a result. Safeguarding alerts had resulted in suitable actions. Where approaches to treatments had resulted in difficulties, the service had learnt from these and had amended treatments to better suit individual patient need. It was not clear however, that all learning reached all staff, particularly rehabilitation assistants.
- Staff followed safeguarding mental capacity and consent procedures.
- The provider used key performance indicators and monitoring tools to gauge the performance of the service and help identify any trends or concerns.
- The manager had sufficient authority and administrative support.
- We saw the risk register contained items related to Janet Barnes unit. These mostly consisted of issues such as parking facilities, which we experienced as a current issue.

Leadership, morale and staff engagement

Good

Services for people with acquired brain injury

- There were no current staff surveys relating to the unit. The most recent survey seen, from 2014, related to the whole of the Christchurch group, the organisation that owned Janet Barnes unit, as well as six other rehabilitation centres around the country.
- There were twelve leavers in the past twelve months, which gave a turnover rate of 8.3%.
- Figures provided by the manager showed 10% staff absence, including sickness, in the past twelve months.
- We did not see or hear of any evidence of bullying and harassment.
- Staff we spoke with told us they knew how to use the whistle-blowing process.
- Clinicians and qualified staff were confident about raising concerns or issues. Rehabilitation staff we spoke with were more positive about raising issues now they had a manager who they felt would listen. They felt managers had not stayed long enough previously for them to get to know them.
- We had a generally positive response from all the staff we spoke with concerning morale, job satisfaction and sense of empowerment. Clinicians in particular were very positive concerning their work. Rehabilitation assistants were less positive, although agency workers and new staff we spoke with were very positive. The manager acknowledged that some longer serving staff might have felt demoralised by the recent history of frequently changing managers, leading to a lack of consistency, leadership and support for care and nursing staff.
- Staff, principally rehabilitation assistants, we spoke with brought up two issues they felt affected morale and engagement. The manager also acknowledged these. One issue was the many changes of leadership. This had made staff unsettled. Another factor was the difficulties presented with the care of one patient, which the service was trying to resolve.
- There were opportunities for leadership development. We spoke with staff who had achieved more senior positions, and two staff who saw opportunities for advancement.
- We saw very positive teamwork and mutual support amongst clinical staff. Some of the rehab staff felt demoralised by the frequent changes in leadership. The prospect of sustained and consistent management gave rise to optimism amongst some staff we spoke with.
- We saw staff being open and transparent in explaining difficulties to patients and carers. An example we witnessed concerned items that had not been supplied in a timely manner, even when this issue was beyond the service's direct control. The nurse concerned then explained how they intended to resolve the issue.
- There were team meetings at which staff could contribute ideas. Clinicians and nursing staff were more confident about contributing ideas than were the rehabilitation staff. The service co-ordinator had recently installed a suggestions box, so that staff could make suggestions anonymously if they so wished.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff receive appropriate supervision in their role to make sure competence is maintained.

Action the provider SHOULD take to improve

- The provider should ensure that Portable Appliance Testing (PAT) is carried out within appropriate timescales and details on portable appliance test stickers should be legible to ensure and evidence this is done.
- The provider should ensure that closer monitoring of training takes place to ensure that mandatory refresher training is undertaken by all staff in a timely manner.
- The provider should ensure that learning from when things go wrong is shared with all staff, including rehabilitation assistants where relevant.
- The provider should consider enabling ways of ensuring greater use of the minibus.
- The provider should, as part of quality assurance, undertake surveys of staff at Janet Barnes unit

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Rehabilitation assistants were not receiving regular supervision to support them to carry out the duties they are employed to perform.** This was a breach of regulation 18(2)(a)