

Kent and Medway NHS and Social Care Partnership Trust

Services for people with acquired brain injury

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXYD2	Neuro-Rehabilitation Unit	The Knole Centre	TN13 3PG

This report describes our judgement of the quality of care provided within this core service by The Knole Centre. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

Summary of findings

Ratings

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

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the Knole Centre neurological rehabilitation ward for adults who require rehabilitation following an acquired brain injury or non-progressive neurological illness by Kent and Medway NHS and Social Care Partnership Trust (KMPT) as good because:

- Staff received training that was specific to the needs of their patients to assist them deliver good care and treatment.
- The ward had a system of governance in place to identify and monitored risks for patients. Staff learnt from incidents to ensure patient safety.
- Patients could access psychological therapies as part of their treatment. The ward had a wide range of staff that came from professional backgrounds to support patients. The ward used appropriate clinical outcome scores to show patients progress was monitored by quantifiable measures. Staff produced a yearly outcome report for the trust.
- Care plans were in place that addressed patients' assessed needs and they were reviewed weekly by the staff team at the multi-disciplinary team meetings.
- Staff received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Patients were treated with compassion, respect and dignity. They were positive about the way staff treated them. They were involved in the planning of their care. Their wishes and needs were integrated into their care plans.
- Patient were admitted based on their clinical need and beds could usually be available quickly. Patient usually stayed for a twelve week period and could have week end stays at home.
- There was a range of therapeutic activities available, on both an individual and a group basis. These included bespoke therapies like hydro therapy, exercise groups and walking practice.
- Ward managers provided good leadership and were visible and accessible to both patients and staff.
- The ward did not separate facilities for men and women, according to paragraph 16.9 of the Mental Health Act Code of Practice, and national guidance regarding the provision of same sex accommodation
- Staff members did not have access to all parts of the ward. Staff members did not have keys to all the doors and used adapted objects such as coins to turn the locks. This presented as a potential risk to patients and staff in the event of a fire.
- There were incidents where staff had not signed medication records to show that prescribed medication like thickening agents for patient's food had been given to patients.

Summary of findings

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

Are services safe?

- Staff received statutory mandatory training in areas such as safeguarding adults and children and they were confident about making a safeguarding referral to protect patients. They also received training that was specific to the needs of their patients to assist them deliver good care and treatment.
- The trust and the ward had a system of governance in place to identify and monitor risks for patients. Staff learnt from incidents to ensure patient safety.
- The recording of medication given to patients was inconsistent. We saw there were incidents where staff had not signed the medication records to show that medication had been given to patients.
- The ward did not meet the requirements relating to separate facilities for men and women, according to paragraph 16.9 of the Mental Health Act Code of Practice. Male and female sleeping areas were not separate on the ward and did not comply with the Department of Health gender separate requirements. Male and female bedrooms were seen to be directly opposite each other on the ward.
- There were nurse vacancies in the ward. Regular agency staff covered the shifts to ensure they met their establishment numbers set by the trust. This also meant the manager sometimes worked as a nurse to address the shortfall.

Are services effective?

- Patients could access psychological therapies as part of their treatment. The ward had a wide range of staff from professional backgrounds to support patients. These included nursing, medical, speech and language, physiotherapy, occupational therapy, psychologists. A psychiatrist was also available during working daytime hours.
- The ward used appropriate clinical outcome scores to show patients progress was monitored by quantifiable measures. They produced a yearly outcome report for the trust and patients.
- Care plans were in place that addressed patients' assessed needs. These were reviewed weekly by the staff team at the multi-disciplinary team meetings. There was also weekly goal planning meetings with the patients.

Summary of findings

- Staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had developed two tools for mental capacity assessments. There was one for complex issues and one for less complex issues. Staff members we spoke with were aware that some patients had fluctuating capacity. There were MCA capacity assessments on each patients care records.

Are services caring?

- We observed patients were treated with compassion, respect and dignity. They were positive about the way staff treated them.
- Patients were involved in the planning of their care. We saw their wishes and needs were integrated into their care plans.

Are services responsive to people's needs?

- Patients usually stayed for a twelve week period and they could have week end stays at home.
- Once discharge had been agreed patients and their relatives decided upon the actual time of discharge themselves, to suit their personal needs.
- Staff ensured patients had a variety of healthy eating options. There was a large easy read laminated menu with a key to assist patients. Each food choice was marked as a healthy option, high energy, soft food or vegetarian food choice. Patients could also request foods that met their treatment or cultural needs.
- There was a transitional living ward which was a self-contained flat with its own bedroom, living area to assist patients become independent.
- All patients we spoke with knew how to raise a complaint. Managers, staff and patients told us they responded to verbal, informal comments or complaints immediately to sort them out.

Are services well-led?

- The trust's vision and values for the service were evident on the ward and known to the staff team.
- The ward had access to systems of governance that assisted them to monitor and manage the service.

Summary of findings

- The staff team produced a yearly outcome report to monitor and improve practice. This was available to the trust, the staff team and patients.
- We found the wards was well-led. There was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day-to-day provision of care and treatment.
- The team had completed specialist neurological rehabilitation training on Bridges self-management programme (the Bridges stroke self-management programme was developed in 2005 to support the delivery of longer term support for stroke survivors) to enhance their practice and encourage patients to make and meet their own personal goals.

Summary of findings

Information about the service

Kent and Medway NHS and Social Care Partnership Trust (KMPT), provided specialist mental health services to meet the mental health needs of adults, who require comprehensive multidisciplinary rehabilitation following an acquired brain injury or non-progressive neurological illness. The Knole Centre is a neurological rehabilitation

ward provides treatment for up to eight men and women who have experienced a head injury or neurological damage. There are a further two beds for people with neuropsychiatric conditions. All care is provided in single rooms, some of which have en-suite facilities.

Our inspection team

The team included a CQC inspector and three specialist advisors. The experience of the team was varied including a hospital manager, a nurse from a neurological rehabilitation ward, a social worker and a student nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited Knole ward at the Sevenoaks Hospital site and looked at the quality of the ward's environment and observed how staff were caring for patients;

- Spoke with 5 patients who were using the service;
- Spoke with 1 relative of patients who were using the service;
- Spoke with the manager for of the ward;
- Spoke with 8 other staff members; including doctors and nurses; and
- Attended and observed one hand-over meeting.

We also:

- Looked at 5 treatment records of patients;
- Carried out a specific check of the medication management on the ward; and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

Patients were very positive about the energy and enthusiasm of the manager and the team. They felt involved in decisions about their care and treatment.

Good practice

- The staff team produced a yearly outcome report to monitor and improve practice. This was available to the trust, the staff team and patients.
- There was a transitional living ward which was a self-contained flat with its own bedroom, living area to assist patients become independent.
- The team had completed specialist neurological rehabilitation training on Bridges self-management programme (the Bridges stroke self-management programme was developed in 2005 improved longer term support for stroke survivors) to enhance their practice and encourage patients to make and meet their own personal goals..

Areas for improvement

Action the provider **MUST** take to improve

The provider must ensure that the requirements relating to separate facilities for men and women, according to paragraph 16.9 of the Mental Health Act Code of Practice, and national guidance regarding the provision of same sex accommodation, are adhered to.

Action the provider **SHOULD** take to improve

- The provider should ensure that staff have access to all parts of the ward. Staff currently used adapted objects such as coins and spoons to turn the locks. We saw that if the lock was held in place then the staff could not gain access to the room. This presented a potential risk to patients and staff in the event of a fire.
- The provider should ensure that the recording of medication given to patients is accurate. We saw there were incidents where staff had not signed to showed that medication had been given to patients. They told us this referred specifically to thickening agents for patient's food. We saw the agent had been prescribed by a GP should be recorded appropriately in line with the medicines policy.
- The provider should ensure that the ward is adequately staffed with nurses in line with the levels set by the trust. There was a shortfall of two full time nurses positions. The ward used agency staff and occasionally the manager worked as a nurse to cover the ward and was counted in the qualified staff numbers. There was a recruitment plan in place.

Kent and Medway NHS and Social Care Partnership Trust

Services for people with acquired brain injury

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
West Kent Neurological Support Services The Knole Centre.	The Knole Centre.

Mental Health Act responsibilities

Some staff told us that they had received training on the Mental Health Act and the Code of Practice. There was no one detained under the Act on the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They demonstrated an understanding of MCA principles. Staff members we spoke with were aware that some patients had fluctuating capacity.
- There was a policy on MCA including DoLS, which staff were aware of and could refer to. The policy included information for staff about what to do after a DOLS

application had been submitted. This included follow up work and reassessment. We saw there was continued follow up to discharge patients and follow the recommendations of the DOLS application.

- The trust had developed two tools for capacity assessments. There was one for complex issues and one for less complex issues. The psychologist completed more complex MCA assessments. Staff members demonstrated an understanding of MCA principles.

Are services safe?

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

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

Summary of findings

- Staff received statutory mandatory training in areas such as safeguarding adults and children and they were confident about making a safeguarding referral to protect patients. They also received training that was specific to the needs of their patients to assist them deliver good care and treatment.
- The trust and the ward had a system of governance in place to identify and monitor risks for patients. Staff learnt from incidents to ensure patient safety.
- The recording of medication given to patients was inconsistent. We saw there were incidents where staff had not signed the medication records to show that medication had been given to patients.
- The ward did not meet the requirements relating to separate facilities for men and women, according to paragraph 16.9 of the Mental Health Act Code of Practice. Male and female sleeping areas were not separate on the ward and did not comply with the Department of Health gender separate requirements. Male and female bedrooms were seen to be directly opposite each other on the ward.
- There were nurse vacancies in the ward. Regular agency staff covered the shifts to ensure they met their establishment numbers set by the trust. This also meant the manager sometimes worked as a nurse to address the shortfall.

bathrooms. The manager had been granted derogation exemption from the trust as the ward did not function as a mental health ward. This meant that the trust policies around ligatures did not apply to the patients in the ward in the same way as in other parts of the trust.

- Ligature cutters were available on the emergency medicine trolley for easy access. The manager told us they would prefer for the ligature cutters to be put in a 'red box' where they would be more secure.
- Bedroom doors and some office doors could be locked from the inside. There was no master key to open the doors. This meant that staff used adapted objects such as coins and spoons to turn the locks. We saw that if the lock was held in place then the staff could not gain access to the room. This presented as a potential risk to patients and staff in the event of a fire.
- Male and female sleeping areas were not separate on the ward and did not comply with the Department of Health gender separation requirements. The bathrooms and bedrooms were used for either men or woman depending on the demand. The manager told us that in the last six months there had been more males than females on the ward, so it had become more difficult to divide the ward by gender. The bathrooms and bedrooms were used flexibly for either men or woman depending on the demand. Some of the bedrooms had en-suites. There was also a female only lounge for women who preferred a women-only environment. On the day of inspection a male and female bedroom were directly opposite and they had to walk past each other's room to use the shower or access other areas in the ward. We saw the ward had tried to maximise patient's privacy and dignity with the use of privacy curtains in the bedrooms.

Our findings

Safe and clean ward environment

- The ward layout enabled staff to observe most parts of the ward. There were two areas around corners that were less visible from the staff office. In order to mitigate this potential risk staff members completed 15 minutes checks of all patients on the ward.
- Staff had carried out assessments of ligature risks which was last updated in December 2014. These included the ligature risks of the long light pull chords in the

- The wards were clean and hygienic. The corridors were clear and clutter free to assist access. Patients were satisfied with the standards of cleanliness on the ward. Regular infection control and prevention audits and cleaning rotas were in place. Staff were seen to follow good hand hygiene regimes to ensure patients were protected against the risks of cross infection.
- Emergency equipment, including automated external defibrillators and oxygen, were in good working order.

Are services safe?

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

The equipment had regular dated checks. Medical devices and emergency medication were also checked regularly. Masks, spare electrodes and easy-read instructions were all together in a single easy-access bag to assist staff. Staff had training in responding to medical emergencies.

- Alarms were available in each room in the wards and we saw that when the alarm was used staff responded very quickly.

Safe staffing

- The trust had carried out a review of the number of qualified nurses required on the ward to provide safe care for patients. The staffing levels were based on the needs of the patients. We reviewed the staff rotas for several weeks prior to our inspection, and saw that the ward relied on agency staff to ensure staffing levels were in line with these levels. In order to minimise any risk and disruption for patients they used the same agency staff. They also included these staff in both training and staff supervision. Two new band five nurses had been recruited and were in the process of going through the recruitment checks to come onto the ward. There was also an active recruitment programme in place to recruit to address the three vacant nurses posts. During the day junior staff grade doctors were available on the ward, and there was out of hours call-out GP at weekends/ nights. There was also a psychiatrist based in the outpatients department on site during working daytime hours available if required for patient assessments.
- The manager told us they had the autonomy to obtain additional staff if required to meet the changing needs of patients. In order to ensure there was two qualified member of staff on duty per shift, the ward manager was included in the qualified staff numbers on shifts four days each month. The manager recognised this was not ideal and stated that this would stop once the additional nurses were in post.
- Agency nurses and bank staff that worked on the ward were very familiar with the service. In some cases they had been working there for up to two years. They received an induction to the ward and were provided with the same information, like health and safety policies and procedures as substantive staff. Staff we spoke with told us agency staff were considered part of the regular team. They said that the same staff worked so frequently the substantive staff didn't notice they

were agency staff anymore. We saw the staff handover was facilitated by an agency nurse who showed a great deal of current and past knowledge of the patients. Patients told us they had good relationships with agency staff.

- Two nurses were on shift at any one time. It was not always possible to have one in a communal area at all times, as they were involved in direct patient care, medication administration and office duties and also there were several communal areas on the ward. We saw that a health care assistant was always present in the communal areas and they could get assistance quickly from the nurses on duty.
- Patients reported that they did get 1:1 time with the nurses and staff on the wards on a regular basis.
- Escorted leave took place regularly and staff we spoke with said they were not aware of any cancellations. Ward activities were both planned and flexible dependant on patient's choice and interests. There was no allocated activity coordinator so it became the role of all of the staff to continue the daily activities. Patients were encouraged to go on visits to their homes at weekends where possible.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of every patient on admission and updated this regularly, and after any incident. All of patients we spoke with told us they felt safe. We reviewed five care files and saw there was regular updates of the trust standard risk assessments for falls, MUST (Malnutrition Universal Screening Tool) and manual handling. They were updated alongside patients changing risk and updated when patients left the ward and returned from leave.
- All patients admitted to the ward had a care plan in place that addressed the risks that had been identified in their current risk assessment.
- Staff and patients we spoke with confirmed that there were no blanket restrictions being imposed on patients on the ward. The majority of patients on the ward had initial DoLS applications, submitted to the appropriate funding authority. Patients who did not have these applications told us they knew they were able to leave the ward at will.

Are services safe?

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

- There were good policies and procedures for use of observation including those to minimise risk from ligature points. These were known to staff we spoke with. The staff told us restraint was not used.
- Staff members spoken with told us there was no use of rapid tranquilisation and seclusion.
- Staff had received training in safeguarding vulnerable adults and children. Staff we spoke with demonstrated an understanding of safeguarding practice and how to recognise a safeguarding concern. Staff were aware of the trusts safeguarding policy. Staff provided examples of safeguarding referrals that had been made.
- There were, in the main, good medicines management practices in relation to the transport, storage and medicines reconciliation. There was a policy in place about medicines management that was known to the staff team. We saw that controlled medicines were safely stored in a double locked cupboard. Patients had a cupboard in their rooms for storage of other medicines. The manager completed regular audits of the medicine management system.
- We reviewed the recording of the administration of medication given to patients. We saw there were instances where staff had not signed the record to show that medication had been given to patients. The manager told us this referred specifically to thickening agents for patients food. We saw the agents had been prescribed by a GP for the patients, so the manager agreed they should be recorded appropriately in line with the medicines policy.
- Staff members had devised several innovative ways to prevent harm to patient from falls. For example, patients identified in their risk assessment as being at risk of fall were, in conjunction with a falls management plan, provided with padding in their clothing to soften any impact and reduce injury.
- There were procedures for children that visited the ward. The manager had identified children visiting the

ward as a potential risk on their risk register. There was also information on their website advising visitors to inform staff if children were visiting the ward so they could offer advice.

Track record on safety

- Information about adverse events or incidents that were specific to this core service were reported on the trusts electronic incident recording system. It was discussed in team meetings and information was then placed on an information board to outline quality indicators. Records confirmed that no serious incident occurred on the ward in 2014.
- The manager also used the trust and their own risk register to identify and monitor risks
- The specialist services business unit sent a summary of serious incidents from across the trust to the ward. These included information about what was in place to improve and learn from them.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise incidents and the process to report them on the trust's electronic incident recording system. The ward manager viewed and monitored all incidents that were then forwarded to the trust. This ensured the trust were alerted to incidents promptly and could monitor and instigate investigations.
- Discussions with staff members and minutes of staff meetings confirmed that learning from incidents was discussed at the ward team meetings. For example, the team recently discussed ways they could take ensure patients cultural needs informed their care and treatment.
- We saw there was a policy on the duty of candour and a poster on wall of the ward. Staff were able to describe how they used it in their work with patients to improve their practice.

Are services effective?

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

Summary of findings

- Patients could access psychological therapies as part of their treatment. The ward had a wide range of staff from professional backgrounds to support patients. These included nursing, medical, speech and language, physiotherapy, occupational therapy, psychologists. A psychiatrist in outpatients on site was also available during working daytime hours.
- The ward used appropriate clinical outcome scores to show patients progress was monitored by quantifiable measures. They produced a yearly outcome report for the trust and patients.
- Care plans were in place that addressed patients' assessed needs. These were reviewed weekly by the staff team at the multi-disciplinary team meetings. There was also weekly goal planning meetings with the patients.
- Staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had developed two tools for mental capacity assessments. There was one for complex issues and one for less complex issues. Staff members we spoke with were aware that some patients had fluctuating capacity. There were MCA capacity assessments on each patients care records.

Our findings

Assessment of needs and planning of care

- The needs of patients were assessed after admission. Care was then delivered in line with their individual care plans. We reviewed five patients' files and saw they each had a pre admission assessment, a referral and a report from any previous episode of care and treatment. This information was used to inform care plans and assist patient transition of care. Any risks to physical health were identified and managed effectively. These were monitored by the assessment coordinator on the ward.
- All patients admitted to the ward had a physical examination assessment and there was on going monitoring of their physical health problems. There

were regular reviews of patient's physical health to ensure any concerns were identified promptly. Identified concerns resulted in an updated care plan and clinical observations were made more frequently.

- Care plans were reviewed weekly by the staff team at the multidisciplinary team meetings. There was also weekly goal planning meetings with the patients. Patients changing needs were documented with a plan in place to address those needs. All care plans were discussed with and signed by the patient. They were personalised, holistic, and recovery-oriented. We observed staff using patients care plans during our visit. Patients had a copy of their care plan.

Best practice in treatment and care

- NICE guidance was followed for prescribing medication. We saw examples of this in patients' records reviewed. For example, if there was a patient with a stroke on the ward. The staff team were able to describe the NICE guidelines they followed.
- Patients could access psychological therapies as part of their treatment. There was a full time clinical psychologist who risk assessed each patient for mental health needs. Patients also had access to a psychiatrist.
- The ward was run by registered nurses who had an overview of the physical health needs of patients. In addition to ensuring regular physical health checks took place they ensured each patient's physical health care plans were kept up to date. They used a rating system to escalate medical concerns. Additional support to address physical health needs was available from a consultant who attended the ward weekly. There was also a duty doctor on site on week days. Out of hours cover and weekends was provided by an on-call GP for the area. There was also coordination with the community team who were staffed by general nurses. The team could refer patients on to the team if they had increased complexity of needs.
- The ward used clinical outcome scores to show the effectiveness of their work. They produced a yearly outcome report for the trust to demonstrate that patient progress was monitored by quantifiable measures. They also identified a work plan for 2015. This included the need to ensure there was a potential discharge destination for each patient documented in their care plan on the first day of admission.

Are services effective?

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

- They used the UK Specialist Rehabilitation Outcomes Collaborative (UK ROC Outcomes measures) including the rehabilitation complexity score (which measured a patient's therapeutic needs and their complexity) for all patients during their rehabilitation period. Baseline assessments for each patient were taken on their admission and reviewed on their discharge. These measurements were then compared to indicate improvement whilst being treated on the ward. Recovery was shown by a reduction in admission and discharge scores. For example, patients with traumatic brain injury scores reduced from thirteen to nine in 2014. These score reductions showed us that patients had a lower therapeutic need and complexity after care and treatment from the staff team which promoted their recovery.
- They also used therapy score and the functional independence measure and functional assessment measure (FIM and FAM measures). These measures show patients' cognitive and psychological functional abilities. The 2014 data showed that all but one patient had increased their abilities during their admission.
- The ward used patient-led goals called the goal attainment scaling (GAS) to evidence patients' recovery. These were goals for the team set after discussion with the patient and if appropriate their family. Thirteen patients were measured in 2014 using this outcome and the ward data showed us each had a positive gain in goal achievement.
- The ward also used a rating system of modified early warning signs (MEWS) to escalate medical concerns. MEWS assisted staff to recognise deterioration in patient's physical health and then make a referral to medical staff. MEWS scores had been calculated for patients in the five records we reviewed. Staff demonstrated a clear understanding of the system and told us they had received training in its completion.
- There were several ward-based audits on going and learning from practice. Audits included those related to infection control and prevention measures, bed rails and hand washing. They were used to identify and address any changes needed to improve outcomes for patients. For example, the need to remind visitors to use the hand washing facilities on the ward frequently to ensure patient safety.
- The staff working on the ward came from a range of professional backgrounds including nursing, medical, occupational therapy, speech and language, physiotherapy and psychologists. A psychiatrist based in the outpatients department on site was also available during working daytime hours. There was also an admission coordinator and an administration assistant.
- Staff received appropriate training, supervision and professional development. The ward manager used electronic staff records to assist them ensure staff had completed their training. Records showed that most staff were up-to-date with statutory and mandatory training. Staff had undertaken training relevant to their role, including safeguarding children and adults. Other training included continence management, diabetes awareness, wound care and tissue viability, life support techniques and epilepsy management. All new staff received an induction before starting work on the ward.
- Staff received managerial supervision every four to six weeks in line with the trusts supervision policy. Clinical supervision could be more frequent. Staff told us they used were able to reflect on their practice, personal development and discuss any incidents that had occurred on the ward during supervision.
- There were regular team meetings. Staff spoke positively about the support they received from their manager and colleagues on the ward.
- There was a system to address staff performance issues. The manager was provided with support through the human resources team. Performance could also be addressed via a professional regulatory body like the Nursing and Midwifery Council (NMC).

Multi-disciplinary and inter-agency team work

- Assessments on the ward were done using a multidisciplinary (MDT) approach. Patient records showed that there was effective multidisciplinary team working taking place. Care plans included advice and input from different professionals involved in patients' care. Patients we spoke with confirmed they were supported by a number of different professionals on the wards.
- MDT meetings took place weekly. There was not one scheduled on the day of our inspection. Staff members told us a consultant led the meetings but different

Skilled staff to deliver care

Are services effective?

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

professionals worked together effectively to assess and plan people's care and treatment. Records from the meetings showed us they were effective in sharing patient information and monitoring their progress.

- Information in patient care records showed us interagency work took place. We saw there was extensive communication with the community team to assist with patient discharge planning.

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

- Some staff told us that they had received training on the Mental Health Act and the Code of Practice. There was no one detained under the Act on the ward.
- There was information about independent advocacy services on the ward. Staff we spoke with understood the need to explain their rights to patients.

Good practice in applying the Mental Capacity Act

- Staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The psychologist completed more complex MCA assessments. Staff members demonstrated an understanding of MCA principles.
- There was a policy on MCA including DoLS which staff were aware of and could refer to. The policy included information for staff about what to do after a DoLS application had been submitted. This included follow up work and reassessment. The initial applications were submitted to the appropriate funding authority. Two

patients had current and appropriate DOLS in place.

There were good follow up notes for patients who were subject to DoLS to support appropriate reassessments as needed. We saw there was work in place to discharge patients and find an appropriate setting for placement as per a recommendation of a DOLS application.

- The trust had developed two tools for capacity assessments. There was one for complex issues and one for less complex issues. For example, we saw there were MCA capacity assessments about care and accommodation for patients with complex discharge issues. Staff members we spoke with were aware that some patients had fluctuating capacity and the need for regular MCA assessments.
- The psychologist and the manager followed the process for best interest meetings used for patients who lacked capacity, where decisions were made in their best interests. We saw that patients and their representatives were involved in complex decisions. On two care records we saw best interest assessments were completed in relation to the patient's care and accommodation.
- Staff members spoken with understood the MCA definition of restraint. They told us if the need ever arose then the MCA definition would be followed.
- Staff knew where to get advice about MCA, including DoLS within the trust: Staff members said they found they found the MCA policy useful. There were arrangements in place to monitor adherence to the MCA within the trust.

Are services caring?

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

Summary of findings

- We observed patients were treated with compassion, respect and dignity. They were positive about the way staff treated them.
- Patients were involved in the planning of their care. We saw their wishes and needs were integrated into their care plans.

Our findings

Kindness, dignity, respect and support

- We observed good interactions between staff and patients within the ward. Staff engaged with patients in a kind, compassionate and respectful manner.
- Patients were treated with care and dignity. They were positive about the way staff treated them. Staff were respectful, for example knocking on doors before entering bedrooms.
- Staff we spoke with were all professional and committed to providing the best service and care they could for patients.

The involvement of people in the care that they receive

- Patients were involved in the planning of their care. We saw their wishes and needs were integrated into their care plans and they signed these plans to show they agreed with the content. They had a copy of their care plan.
- There were weekly patients meetings with the minutes on display for patients to read and help inform service delivery. There was also a “you said and we did” board which showed examples of the work the staff had put in place to meet patients request and needs. One example was the introduction of skype (a communication system) for patients to talk with families either locally or overseas.
- There was evidence that carers were involved where possible. Carers we spoke with said they felt involved in their relatives care.
- There was clear data from in the wards outcomes report dated 2014 in relation to patient feedback and satisfaction. Data included satisfaction with the environment, therapy provision and goal setting. This showed us that 71% of patients during 2014 were very happy or happy with their care. The remaining patients reported that they were satisfied with the care provided by the team.

Are services responsive to people's needs?

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

Summary of findings

- Patients usually stayed for a twelve week period and they could have week end stays at home.
- Once discharge had been agreed patients and their relatives decided upon the actual time of discharge themselves, to suit their personal needs.
- Staff ensured patients had a variety of healthy eating options. There was a large easy read laminated menu with a key to assist patients. Each food choice was marked as a healthy option, high energy, soft food or vegetarian food choice. Patients could also request foods that met their treatment or cultural needs.
- There was a transitional living ward which was a self-contained flat with its own bedroom, living area to assist patients become independent.
- All patients we spoke with knew how to raise a complaint. Managers, staff and patients told us they responded to verbal, informal comments or complaints immediately to sort them out.

- Staff told us patients were not moved between wards during an admission episode unless there was an emergency situation like severe breathing difficulties. In such cases the patient may be taken to A&E for assessments and possible admission to hospital.
- We were told by staff that once discharge had been agreed patients and their relatives decided upon the actual time of discharge themselves, to suit their personal needs. The ward data showed that in 2014 over 70% of patients were discharged to their own homes. Around 23% of patients were discharged to either nursing homes or other rehabilitation settings. Discharge could sometimes be delayed if, for example, patients identified placements needed specialist equipment before they could be admitted. Patients could also experience delays if they were waiting for funding or if the patients needs were of a complex nature and placements were difficult to find. In 2014 56% of patients stayed between twelve and twenty weeks on the ward and 13% stayed between twenty and thirty weeks.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms and facilities, including areas for activities, therapeutic interventions, clinics, kitchens and communal areas. There was also a transitional living ward which was a self-contained flat with its own bedroom, living area to assist patients become independent.
- There were no dedicated quiet rooms on the ward so patients used their own rooms to meet visitors in private. The manager told us female patients also used the female lounge as a quiet area. Male patients used the shared lounge or the staff handover room when not in use. The self-contained flat also could be readily accessed. The manager told us a quiet space could be easily found and patients and relatives confirmed this was the case.
- Patients signed a disclaimer form about the wards responsibilities in the use of mobile phones and then they could use their own phones. There was also a ward mobile phone that they could use at any time. The

Our findings

Access and discharge

- The manager told us that, where a patient needed to be admitted based on their clinical need, a bed could usually be available quickly. Although we noted that the staff team did not include any monitoring of patient waiting times in their outcome report 2014. The service covered west Kent and Medway catchment area. There were 23 patients in the ward between January 2014 and December 2014 and composed of ten females and 13 male patients.
- The manager told us patient usually stayed for a twelve week period. They could have week end stays at home after the occupational therapist (OT) had completed a home visit to establish if the patient could be cared for safely within their home environment. The OT would check if, for example, it was wheelchair accessible. The manager told us the patient always had access to a bed on return from leave.

Are services responsive to people's needs?

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

manager told us the ward used to have a pay phone but patients rarely used it. Patients we spoke with confirmed that they had sufficient privacy to make a private call.

- There was an outside garden which was accessible via the ground floor garden room. Patients used the lift to get to the garden room. Staff members and patients told us to they used the garden a great deal in the summer months.
- Patients were very complimentary about the quality and range of meals available on the ward. The staff team ensured patients had input into the menu. This was discussed at the community meetings and patients were also given questionnaires at the point of discharge. The manager told us senior staff met with the chef at Sevenoaks hospital who prepared the food. They devised a service level agreement to ensure patients had a variety of healthy eating options.
- Staff ensured patients had choices about the food they wanted to eat. There was a large easy read laminated menu with a key to assist patients. Each food choice was marked as a healthy option, high energy, soft food or vegetarian food choice. Patients could also request foods that met their treatment or cultural needs. These included puréed foods or halal meat. Patients could have snacks of their choice made in the ward kitchen areas.
- Patients had to complete a competency test with the OT to ensure they could prepare their own food safely independently. They could then make their own drinks and snacks in the dining area or the OT kitchen. Patients confirmed there were no time restrictions on accessing these areas.
- We saw that patients could personalise their bedrooms with their own pictures, possessions and bedding.
- All patients had a small lockable cabinet in the bedrooms along with a cupboard and chest of drawers in which to store their possessions. Patients could also keep their property in a locked cupboard in the clinical room.
- There was a range of therapeutic activities available, on both an individual and a group basis. These included bespoke therapies like hydro therapy, exercise groups and walking practice. Patients told us how they were no therapy groups at weekends. At the community

meetings they told the staff team that weekends could be boring. The staff team addressed this by including a range of games and puzzles and some community based activities. Patients we spoke with were satisfied with the range of activities available.

Meeting the needs of all people who use the service

- There were a range of adjustments for people requiring disabled access. These included a lift and a ramp to the patio and garden area to assist wheelchair users. Corridors and door frames were wide enough to facilitate wheelchair use. There were hand rails in patient's bathroom and four of the showers on the ward were of the easy walk in variety to assist patients with limited mobility.
- There were information leaflets about the wards, services, advocacy arrangements on the ward. The manager told us that they could access leaflets in different languages and formats via the trust communication team to meet the needs of patients for whom English was not their first language. They could also access a translator if required to assist patients.

Listening to and learning from concerns and complaints

- Records confirmed that there were no formal complaints made to the manager in 2014. The manager told us that if there were any they would follow the trusts complaints policy and procedure.
- The manager and staff told us they responded to verbal, informal comments or complaints immediately to sort them out. The manager told us one patient had complained about how unappetising the puréed foods looked when foods were all mashed up together. The speech and language therapist then ensured the food provider separated the foods. The manager told us they didn't formally record these complaints but they wrote it up on the "you said, we did " board in the ward. This was updated every two weeks and gave the manager the opportunity to monitor, analyse and look for trends in complaints made by patients.
- All patients we spoke with knew how to raise a complaint. The patient booklet included information on how to make a complaint. There was also information about how to access advocacy to support patients make

Are services responsive to people's needs?

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a complaint. Further assistance could be accessed via the trusts website. This included information about the patient advice and liaison service (PALS) which also supported patients raise concerns.

- At each community meeting patients were asked if they had any comments about the service they received. If any complaints were made then they were addressed quickly by the team.

Are services well-led?

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

Summary of findings

- The trust's vision and values for the service were evident on the ward and known to the staff team.
- The ward had access to systems of governance that assisted them to monitor and manage the service.
- The staff team produced a yearly outcome report to monitor and improve practice. This was available to the trust, the staff team and patients.
- We found the wards were well-led. There was evidence of clear leadership at a local level. Ward managers were visible on the wards during the day-to-day provision of care and treatment.
- The team had completed specialist neurological rehabilitation training on Bridges self-management programme (the Bridges stroke self-management programme was developed in 2005 to longer term support for stroke survivors) to enhance their practice and encourage patients to make and meet their own personal goals.

Our findings

Vision and values

- The trust's vision and values for the service were evident and on display in the ward. There were also examples of how the wards were meeting these values on display. Staff told us they understood the vision and direction of the trust in delivering good care and treatment for patients.
- The ward managers had regular contact with their line manager. Staff members we spoke with knew the names of senior trust managers and told us the director of nursing had visited the ward.

Good governance

- The ward had access to systems of governance to monitor and manage the service and provide information to senior staff in the trust. One example of this was the electronic staff record that monitored staff appraisals and training that staff had received. Emails from the trust informed staff and their managers when appraisals and training needed to take place.
- The manager told us there were no individual key performance indicators, but the team worked closely to

improve outcomes for patients. They produced a yearly outcome report to evidence their work and to improve practice. They used the rehabilitation complexity scales to measure patient's therapeutic needs and complexity. In 2014 these measures showed an improvement in patients admitted to the Knoke centre. They also monitored the performance of the ward in relation to staff sickness reporting, staff turnover, staff supervision, discharge, length of stay and patient satisfaction.

- The ward manager told us that they had enough time and autonomy to manage the ward. They also said that, where they had concerns, they could raise them with the trust.

Leadership, morale and staff engagement

- We found the ward to be well-led. There was evidence of clear leadership. The ward manager was visible on the ward during the day-to-day provision of care and treatment. Staff members we spoke with said the manager was very accessible and supportive. There was an open culture on the ward. Staff were invited to bring forward ideas for improving practice and the patient experience. Staff members were particularly proud about the menus and improved food choices for patients.
- The ward staff we spoke with were enthusiastic and motivated. They were proactive and made suggestions for improvements. They felt able to report incidents and raise concerns. They were confident they would be listened to by their line manager. They were open about the historic challenges they had about the provision of care on the ward and were confident in the improvements they had now put in place.
- Many staff told us that there had been significant changes in the ward following an incident a few years ago. There were many staff changes and improvements made to practice to ensure patient safety. Staff felt the ward had improved and this was confirmed by patients, the new systems in place and the low levels of complaints. Staff were positive about the trust and said they were kept up to date about developments through regular emails and information on the online staff zone.
- Sickness and absence rates were monitored every month. In January 2015; the levels were 1.5% on the ward.
- At the time of our inspection staff members told us there were no allegations of bullying or harassment within the ward.

Are services well-led?

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

- Staff were aware of the whistleblowing process if they needed to use it. They told us there was a 'green button' with the staff zone on their intranet where staff could report any concerns they had. Staff told us they were able to report any concerns without fear of victimisation.
- The manager told us they had access to leadership training and development. They felt supported by their immediate line manager. Staff members we spoke with told us staff morale was good.

Commitment to quality improvement and innovation

- The team had completed specialist neurological rehabilitation training on the Bridges self-management programme (the Bridges stroke self-management programme was developed in 2005 improved longer term support for stroke survivors) to enhance their practice and encourage patients to make and meet their own personal goals. Evidence in the outcome report 2014 showed there was a positive impact of this programme on patients.

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	<p>Regulation 15 HSCA 2008 (Regulated Activities)</p> <p>Regulations 2010 Safety and suitability of premises</p> <p>Regulation 15 HSCA 2008 (Regulated Activities)</p> <p>Regulations 2010 Safety and suitability of premises</p> <p>The premises where regulated activity is carried on was not protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout appropriate measures in relation to risks of the premises to patients and adequate repair or maintenance of the premises. There were not always separate areas or facilities for men and women.</p> <p>This relates to the safe domain at the Knole Centre.</p>