Royal Hospital for Neuro-Disability

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Hospital for Neuro-disability is an independent medical charity which provides neurological services to the entire adult population of England.

The hospital specialises in the care and management of adults with a wide range of neurological problems including those with highly dependent and complex care needs, people in a minimally aware state, people with challenging behaviour and people needing mechanical ventilation.

The hospital was inspected in June 2015 and not rated as that was a pilot inspection. This inspection has followed up on issues identified in the June 2015 inspection and the hospital is now rated.

Our key findings are as follows:

- We found improvements in all the areas of concern that we had identified in the previous inspection, such as staff understanding of the mental capacity act and lack of patients and residents with authorisations for deprivation of liberty safeguards, staff understanding of aspects of duty of candour and safeguarding. Medical cover had improved and efforts were being made to make the environment for long term residents more homely, and the quality and presentation of food was better.
- There were systems to report and investigate incidents, to control the spread of infection, to manage medicines in line with legislation and current guidelines and to report and investigate suspected abuse
- We saw good use of audit to assess progress of patients
- There were enough staff to care for patients and residents.
- Patient records in the BIS and the specialist unit reflected a multi-disciplinary approach to care with individual outcome goals that were regularly reviewed.
- Research was beginning to influence patient care.

We found some outstanding practice, particularly the wide availability of a range of advanced communication aids such as eye gaze technology customised to the needs of the individual, and the support to patients, residents, families and staff by the chaplaincy service. .

However, we also found areas where that the provider needs to improve.

Importantly the provider must:

- Ensure ward staff have more training both on the different degrees of decision-making ability among patients and residents, and the types of decisions each is able to make, and also on the risks to patients and residents of not following the guidance for eating and drinking.
- Ensure all staff have an annual appraisal

In addition the provider should;

- Ensure staff are encouraged to record patient notes contemporaneously, and have time to do this.
- Improve standards of hand hygiene.
- Ensure that all residents in the specialist nursing home have all aspects of their care plans reviewed at intervals in line with national practice.
- Adopt a more structured process for handling complaints, working with the complainant as a far as possible to ensure both sides were satisfied with the outcome.
- Ensure that patients' fluid balances are monitored systematically by adding up fluid balances on charts.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Royal Hospital for Neuro-Disability

The Royal Hospital for Neurodisability is a residential independent hospital run by a charity. It is located in Putney, West London. The hospital opened in 1854 and has been in the current location since 1863. The hospital is in a three-storey listed building with a basement area used by administrative staff.

Patients and residents come mainly from London and southern England, but some come from other parts of England. RHN provides acute assessment and rehabilitation for 52 patients with severe brain injuries or illness from all over England, through the NHS England Specialist Rehabilitation Contract.

The hospital provides specialist help to patients with a wide range of complex neurological disabilities caused by damage to the brain or other parts of the nervous system as a result of brain haemorrhage, traffic accidents or progressive neurological conditions such as Huntington's disease or motor neurone disease. It includes people who are highly dependent and have complex care needs, people in a minimally aware state, people with challenging behaviour and people needing mechanical ventilation. RHN has a high dependency nursing home providing long term care for about 122 residents who have become disabled following a brain injury. RHN is registered to provide diagnostic and screening activities, diagnosis and treatment, accommodation for people needing nursing or personal care and transport, triage and medical advice provided remotely.

The registered provider is required to have a registered manager. The Chief Executive had applied to be the registered manager before the inspection. Registered managers have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, two assistant inspectors, and specialist advisors with expertise in rehabilitation, brain injury, neurology, neuropsychology, end of life care as well as a speech and language therapist, occupational therapist and physiotherapist.

The team also had an expert by experience, someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

The inspection team was overseen by Nick Mulholland, Head of Hospital Inspection

How we carried out this inspection

We inspected the hospital as part of our announced inspection between 28 and 30 March 2017 and again in an unannounced inspection on 12 April 2017, in late evening.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We observed how patients and residents were being cared for, spoke with patients and residents, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospital, including doctors, nurses, therapists, administration and other staff. We also interviewed senior members of staff at the hospital.

Summary of this inspection

Before, during, and after our inspection we reviewed the hospital's performance information.

Information about Royal Hospital for Neuro-Disability

The Royal Hospital for Neuro-disability has three service areas: the Brain Injury Service, the Specialist Services and the long term specialist Nursing Home.

The Assisted Augmented Communication Service, commissioned by NHS England, supports inpatients in the brain injury service and other patients and residents in the Royal Hospital through an internal referral system.

The Brain Injury Service (BIS)

- The Brain Injury Service has two main pathways: Rehabilitation, and Prolonged disorders of consciousness (PDOC). The latter term (PDOC) describes patients remaining in a coma, a vegetative state (VS), or a minimally conscious state (MCS) after a brain injury.
- The rehabilitation ward is Drapers ward. Specialist assessment and rehabilitation aim to optimise patients' physical, communicative and cognitive function.
- The PDOC pathway on Devonshire and Clifden wards provides specialist assessment, diagnosis and disability management planning for people living with a disorder of consciousness.
- 80% of patients on BIS wards lack capacity to consent to their admission and require Deprivation of Liberty Safeguards. The average length of stay is 120 days, up to a maximum of 180 days. About 25% of patients return home and 75% transfer to a specialist Nursing Home.

Summary of this inspection

The Specialist Services
These comprise three distinct services:

- A ventilator unit with 16 beds for people needing mechanical assistance with breathing because of neurological disease, incident or high spine injury.
- Two specialist wards are for patients with Huntington's disease: Wolfson ward has 14 beds for patients with Huntington's disease and Coombs ward has 12 beds for patients with late stage Huntington's disease. The NHS funds these services NHS under continuing care.
- A Neuro-behavioural Rehabilitation Unit (NRU) on Wellesley ward cares for 13 patients with complex neuro-disabilities who also display challenging behaviour. Treatment focuses on assessment, behaviour management and long term care. The behavioural unit is managed by a consultant in rehabilitation medicine and a part-time visiting consultant neuro- behavioural psychiatrist from an acute tertiary hospital. The consultants provide care in conjunction with a multi-disciplinary team. Clinical commissioning groups (CCGs) fund these patients.

The Specialist Nursing Home
This provides for patients with progressive neurological conditions or acquired brain injury requiring 24 hour care. This includes residents with a diagnosis of PDOC.

- The six wards in the Nursing Home Evitt, Glyn, Andrew Reed, Cathcart, Hunter and Chatsworth take patients of broadly similar levels of awareness. Evitt ward is mainly for younger residents, 18-40 years.
- RHN's nursing staff and therapists mainly worked specifically in one of the three services, but some therapists and doctors worked across one or more services.
- During the inspection, we visited all wards and units. We spoke with over 40 staff including registered nurses, health care assistants, ward clerks, activity coordinators, volunteers, medical staff, therapists and senior managers. We spoke with 6 patients and 20 relatives. We also received 12 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 20 sets of patient records.
- There were no special reviews or investigations of the hospital by the CQC at any time during the 12 months before this inspection.
- The hospital has been inspected four times, and the most recent inspection took place in June 2015, the first inspection of this type of service under CQC's new comprehensive inspection methodology. At that inspection we found the hospital was not meeting all standards in relation to patient consent and the mental capacity act; safe care and treatment; safeguarding, and staff understanding of the duty of candour. We followed up the requirements identified in the June 2015 inspection in this inspection and the hospital was found to be compliant in the areas identified in 2015.

Activity (October 2015 and September 2016)

- The hospital had 240 beds.
- 122 residents were in the specialist long term Nursing Home, living in six wards. 52 of these residents had a diagnosis of prolonged disorders of consciousness.
- 55 residents were in the four wards within the Specialist Services.
- 52 patients were in the three wards that comprised the Brain Injury Service, of which 16 had a diagnosis of prolonged disorder of consciousness. NHS England funded 39 of these patients.

Summary of this inspection

- Overall 95% of patients and residents were NHS funded and 5% were funded by other means.
- At the time of the inspection, RHN employed 10.1 whole time equivalent (WTE) doctors and 0.45 WTE dentists. A Richmond-based GP provided medical services to residents of the long term Nursing Home and to patients with Huntingdon's disease. Radiographers worked two days a week. The hospital employed 68.5 WTE qualified allied health professionals (AHP) and 56.5 WTE support AHPs. Allied Health Professionals include Physiotherapists, Speech and Language Therapists, Occupational Therapists.
- RHN employed 104.8 WTE registered nurses and 170 WTE healthcare assistants as well as having its own bank staff to cover unfilled shifts.
- The accountable officer for controlled drugs (CDs) was the chief pharmacist.

Track record on safety:

- No reported Never Events
- Four reported serious incidents, three resulting in moderate harm and one in low harm
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA), or hospital acquired E-Coli.
- Three instances of hospital acquired Clostridium difficile (c diff)
- One reported hospital acquired venous thrombo-embolism (VTE)
- 16 deaths, of which three were referred to the coroner.
- 20 formal complaints made to the hospital.

Services accredited by a national body:

Level 1 rehabilitation service specification; Augmentative and Assistive Communication (AAC) accreditation; Membership of the Independent Neurological Rehabilitation Association; Membership of the Association of Medical Research Charities; Schwartz round Licensee:

Services provided at the hospital under service level agreement:

Clinical and non-clinical waste removal; Medical gases; Grounds maintenance; Laundry; Maintenance of medical equipment; Pathology and histology; Preferred provider for agency staff.

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?

Requires improvement

We rated safe as requires improvement because:

- Many patients and residents were at risk of choking whilst eating or drinking. Some staff supporting people with eating and drinking had limited understanding of the consequences of not observing the care plan/meal mat. There were no dysphagia trained nurses.
- Mandatory training was below the target of 95% in safeguarding and cardiopulmonary resuscitation where the rates for training were 77% and 86% respectively.
- Although we observed good hand hygiene practice on inspection, the audit results showed scores of 60% which was lower than the hospital's target.
- Record keeping was of variable standard and less good in the nursing home.
- Some residents in the nursing home had not had all aspects of their care plans updated in more than a year.
- Patients fluid balances were not systematically monitored. We found no totalled fluid balances in any ward in the hospital.
- Staff did not record patient notes contemporaneously which meant there was a risk staff might forget to record some points.
- Medicine administration incidents occurred almost daily, which was high for a hospital this size.
- Understanding of risks to patients and residents was inconsistent among healthcare assistants.

However

- There were clearly defined systems to report, investigate and learn from incidents and when things went wrong, to help ensure patients and residents were protected from avoidable harm.
- Pressure ulcer management was carried out well. Information about the number of pressure ulcers, catheter-induced urinary tract infections and complaints for the each month, were displayed on each ward.
- The hospital was visibly clean.
- The hospital scored better than the national average in most areas of the Patient-Led Assessments of the Care Environment in 2016.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Policies, procedures, care and treatment were based on best practice from NICE/Royal College guidelines.
- We saw good evidence of multi-disciplinary working.
- We found appropriate use and documentation of MCA, including best interest decision-making involving families where possible.

However

- Many staff, particularly in the nursing home, did not understand the need to support people to communicate their wishes and did not understand the degrees of decision making-ability for different decisions.
- Not all agency staff we observed were confident in their skills and experience to meet patients' needs.
- Staff appraisals were below the target of 95% in all areas - only 68% in specialist services and 78%in the nursing home.

Are services caring?

Good

We rated caring as good because:

- We saw a good level of personalisation of care for patients, particularly when compared to similar units for patients with a diagnosis of PDOC.
- The leisure service tailored the extensive range of activities to residents' interests.
- Family members were encouraged to visit their relative, and staff asked them how they would like to be involved in their relative's care.
- Most families and patients, where possible, had a reasonable understanding of the care plan
- Feedback from patients and those who were close to them was generally positive about the way staff treated people
- Permanent staff were well motivated and offered care that was kind and promoted dignity. Relationships between staff and patients and residents were generally caring and supportive.
- Staff took personal, cultural, social and religious needs into account in providing care and arranging activities.
- The chaplaincy service provided outstanding emotional support to patients, residents, families and staff.

However

- We reviewed the results of a survey of communicating with patients with complex communication needs which indicated there was room for improvement on staff understanding of the importance of communication and having time to communicate.

Summary of this inspection

- Some families reported that staff could be abrupt, particularly night staff.

Are services responsive?

Good

We rated responsive as good because:

- An extensive range of leisure activities were provided.
- There were regular bed management meetings and the hospital contacted referrers to keep them up to date with progress about securing a bed.
- Patients' and families' preferences were taken into account in planning and delivering care
- A wide range of leisure activities were arranged.
- Every patient and resident had individualised information about their preferences, their positioning needs, dietary needs meal mats, which gave information to staff and volunteers.
- A wide range of therapy sessions were available including music and relaxation therapies such as massage.
- There was accessible information for patients and relatives on how to make comments, compliments, suggestions or complaints.

However

- The complaints handling process lacked a structured approach and staff did not follow up with families whether they were satisfied with the outcome.
- A number of family members mentioned to us that clinicians did not take enough account of their views.
- A number of agency staff were observed to be very task focused and did not take time to understand the individual needs of the patient and residents as set out in their care plans.
- Some wards were clinical in appearance and in need of refurbishment.

Are services well-led?

Good

We rated well-led as good because:

- The executive team were visible and supportive and had a clear vision and strategy for improvement. Staff understood the values of the organisation.
- There was a robust governance framework and annual plan. There were clear reporting lines and areas of responsibility, with structured meetings. All members of the multi-disciplinary team were seen to be actively engaged in the governance of the organisation.
- The wards in the Brain Injury Service, in particular, were well led by their ward managers.

Summary of this inspection

- There was a range of audits to improve quality, although the results indicated in some cases that training was not effective in embedding good practice.
- Staff attended Schwartz rounds to discuss the emotional and social aspects of their work.
- The hospital's innovation programme for patient with a diagnosis of prolonged disorders of consciousness (PDOC) included the training and development of staff.
- The hospital had systems for gathering feedback from patients and their families and gathering their views on delivery of care.

However

- Nurses and healthcare assistants did not always work as a team and some healthcare assistants felt unsupported on wards. We observed higher levels of satisfaction across other staff groups as compared with healthcare assistants
- At the time of the inspection the hospital had made little progress in complying with equality and diversity standards and the workforce race equality standards in the NHS contract, although had plans to comply by January 2018.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long term conditions	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Long term conditions

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

Are long term conditions safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- The hospital did not report any Never Events in the period from March 2016 to February 2017. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.
- There were three unexpected deaths during the reporting period. There were four reported serious injuries, three with moderate and one with low harm.
- There were 1103 incidents reported in the previous year (October 2015 to September 2016). Nearly all of these incidents (97%) were low or no harm. This suggested a good reporting culture at the hospital, although some staff said there was less reporting at night and at weekends. All staff had access to the electronic system to report incidents. Following the inspection the provider told us that they would expect a lower level of reporting at night because there was less clinical activity. Their analysis of three months of data showed 16.6% of incidents were reported at night.
- Incidents were reviewed daily at ward level. Any incident deemed to be a safeguarding issue was reported to the local Adult Safeguarding team. Serious incidents were reported to the Clinical Commissioning Group funding the patient. Fortnightly risk and incident meetings reviewed themes and focused on learning from incidents in order to prevent recurrence.
- We were told root cause analysis (RCA) investigations were undertaken for serious incidents and safeguarding, although not all senior staff had RCA training. Ward managers discussed incidents every two weeks at an incident review meeting, and discussions also took place at the matrons' meeting, with the Head of Nursing and Head of Patient Safety & Quality. Minutes showed that lessons learned from incidents investigated were shared at these meetings. Learning points were also recorded on ward files to facilitate local discussion.
- Some recurrent themes of incidents during the reporting period were low level medication errors, gastrostomy care, tracheostomy management, clogging of showers, broken down lifts and staff giving patients meals out of line with the instructions on their meal mat and in their care plan.
- There was evidence of responding to incidents by providing additional staff training, for example in relation to tracheostomy care (tracheostomy is an incision in the windpipe made to relieve an obstruction to breathing). Managers escalated some incident trends for inclusion on the clinical risk register, for example a series of incidents around insulin for patients with diabetes.
- The RHN Patient Safety & Quality Committee was chaired by a trustee and received a full report of incidents, complaints and concerns quarterly.
- A reconstituted, multidisciplinary Mortality Review Committee (MRC) started in October 2016, led by the medical director. This covered all deaths, including deaths in an acute hospital and deaths within 30 days of

leaving RHN in line with standard practice. It met monthly. The consultant or GP responsible for the patient or resident led the review using a mortality template to ensure consistency.
- Morbidity was reviewed by the Clinical Risk and Incident Committee which met every other month.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. This regulation relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person
- At our previous inspection we had identified that not all staff understood the application of duty of candour. We saw evidence on this inspection that all staff had completed an e-learning module on duty of candour principles. We asked staff what duty of candour meant and they mentioned being open and honest with patients and families when something went wrong.
- A compulsory duty of candour field in the incident reporting system prompted ward managers to consider the possible need for a duty of candour response. Heads of service were responsible for writing to patients and relatives in the event of an incident causing harm or had the potential to cause serious harm. Incidents requiring a duty of candour response were reported to the executive team, evidenced by the monthly executive team minutes.

Brain injury service

- Of the four serious incidents in the hospital, only one was in the brain injury service, in December 2016. This related to a patient's one way tracheostomy valve being removed and not immediately replaced.
- Only one of the sixteen patient deaths was in the brain injury service (Clifden Ward) in January 2017. We reviewed the mortality review record for this patient which was completed in appropriate detail.

Challenging behaviour unit

- Incident reporting on this unit was slightly different to the rest of the hospital because of the nature of the patients' behaviour. The type of incidents reported were those where a patient's actions were different from their routine behaviour pattern or caused injury to themselves or others.

Safety thermometer

- The hospital monitored incidents such as pressure ulcers, falls, urinary tract infections (UTI) and hospital-acquired venous thrombo-embolism (blood clots) under the NHS safety thermometer, a point of care survey conducted one day a month. Comparison with the national average for rehabilitation services and national neurology services showed RHN to be consistently above the national average of 94% for the delivery of harm-free care. The RHN average was 97.6%. Information on this was displayed on wards.
- Data for the year from March 2016 to February 2017 showed there were 22 hospital-acquired pressure ulcers at RHN (all low grade, level 1 or 2), 2 falls, none with harm and three UTIs in patients with catheters. This was a low level of incidents of this kind.

Cleanliness, infection control and hygiene

- The hospital wards, bedrooms, communal areas and corridors were visibly clean and well-lit. Wards had assigned domestic staff. Sluice rooms and bathing facilities were clean and tidy.
- Schedules of ward cleaning frequency were displayed in each area and we noted the schedules varied depending on the risk status of patients on the ward. Discussion with domestic staff showed they understood the principles of infection control in the areas they worked. Deep cleaning was arranged when a person had had an infection.
- Infection control information notices were displayed on entry to wards, informing staff and visitors to use hand sanitizing gels, before entering and leaving the wards. There were ample hand sanitizers on the wards for use by staff and visitors.
- We observed all staff were 'bare below the elbow' on the wards in line with good practice.
- Staff followed policies on hand hygiene and we observed good hand washing practice to prevent the spread of infection.
- We saw staff wearing personal protective clothing where appropriate. Disposable aprons were colour coded, depending on whether the staff were carrying out personal care or feeding patients/residents. Gloves were available in different sizes.
- Training on infection prevention and control was mandatory. The Director of IPC was the Director of Nursing; an IPC clinical nurse specialist took the lead on

advice on infection control and had a monthly protected time slot at the senior nurse forum to talk about infection control. Ward managers acted as link nurses for IPC.

- 'I am clean' stickers were used on equipment to show it was ready for clinical use.
- Staff carried out tracheostomy checks regularly including changing the inner tube, changing the dressings and using suction machines to keep patient airways clean and clear.
- Staff screened patients for MRSA on admission. The hospital also routinely screened patients for MSSA, Clostridium difficile (C diff) and E Coli.
- The hospital screened inpatients for carbapenemase producing enterobacteriae (bacteria that are resistant to antibiotics) to ensure early detection, in line with good practice. The hospital had worked with Public Health England when a cluster of incidents had occurred the previous year to improve practice. Staff carried out extended screening in the ventilator unit, where patients were at higher risk of infection.
- Audits enabled effective monitoring of IPC: an annual IPC audit, an audit of anti-microbial usage and six monthly audits to monitor hand hygiene and adherence to the hygiene code (the code of practice for the prevention and control of infections describes the standard precautions that must be taken with all patients at all times regardless of their known infection status). Ward managers observed hand washing monthly to record whether any person who had contact with a patient, or a patient's environment, had adequately and appropriately decontaminated their hands, either by washing their hands with soap and water, or by using hand sanitisers.
- Hand hygiene results, from an audit in May/June 2016 were lower than target. The highest scoring units were the ventilator unit and Drapers ward, but no ward results were above 60%. Nurses were running additional training aiming to raise standards.
- RHN had a C-reactive protein machine as an indicator to test for inflammation in the body before sending blood samples for culture. On weekdays, courier took blood samples to a pathology laboratory. The hospital did not analyse blood cultures on site.
- RHN had a Water Safety Group, a sub-committee of the IPC committee, involving engineers, estates and a microbiologist. Water contamination by pseudomonas (a pathogen that can cause disease in immuno-compromised patients) had been found in 2013. The water was therefore regularly checked and filters had been installed in some showers to reduce the risk. There were also quarterly checks for Legionella, which had been found intermittently in some wards. The provider followed the assessor's recommendations in response to findings of water contamination.
- The hydrotherapy pool water was tested three times a day for microbiological contamination that could cause disease. There was a decontamination procedure.

Environment and equipment

- The environment was tidy. The corridors were wide and free of clutter, which enabled safe movement around the hospital for wheelchair users.
- We observed staff moving and handling patients safely, using equipment such as hoists, standing aids and mobile turntables for transferring patients. Slings were specific to individual patients. There was a capital programme to increase the number of overhead hoists.
- Staff told us they had training in waste management. When asked they were able to describe appropriate segregation of waste and we did not see problems with waste segregation during our inspection.
- The hospital completed a patient-led assessment of the care environment (PLACE) survey in 2016. This system uses patient representatives to visit hospitals to assess food, cleanliness and general building maintenance, and how the environment supports patients' privacy and dignity. In the PLACE audit 2016, RHN scored 99.97% for cleanliness and 99.4% in relation to the general building maintenance of the hospital which was better than the national average of 93%.
- Almost every resident used a wheelchair. The layout of the building ensured all areas were wheelchair accessible and there were lifts in some areas. Over half had wheel chairs offering a tilt-in-space facility which enabled staff to tilt chairs at different angles to enable redistribution of pressure and avoid pressure damage to the skin.
- BIS patients had loan wheelchairs from RHN and about one-third of residents had customised and bespoke wheelchairs, for which the hospital provided an annual maintenance service. Other wheelchairs were purchased and provided by the funding body, typically by the CCG. A specialist wheelchair team on site responded to any immediate maintenance issues.

- There was not enough space for storage of wheelchairs in some wards. For example, in Jack Emerson Centre, wheelchairs were kept in the shower room at night and staff had to move them into the corridor when patients had showers.
- The estates department had a regular equipment check programme. We noted the hoists had been recently checked in line with UK Lifting Operations Regulations. Electrical safety tests on portable equipment and fire equipment checks were in date. Sharps boxes were correctly assembled and clearly labelled in compliance with Health and Safety (Sharp Instruments in Healthcare) regulations 2013.
- Staff followed the guidelines of the Aquatic Therapy Association of Chartered Physiotherapists (ATACP) for the hydrotherapy pool. Physiotherapists carried out risk assessments for patients using the pool to assess length of time in water, entry and exit and implications for emergency evacuation.
- Therapists used technology to help patients improve upper limb functionality with appropriate patients. The software provided automatic, ongoing assessment of motor functions so patients could track their progress and reach therapy goals. Other patient-specific equipment was available to meet particular needs: eye gaze technology was an example.
- Emergency equipment was available on the wards. These included oxygen cylinders and piped oxygen, automated defibrillators and suction machines. We saw that they were checked daily and ready for immediate use. Audit confirmed compliance with checking.
- There were arrangements to ensure the site was secure. The site was monitored by CCTV and there was buzzer controlled access to all patient and resident areas. There was a security guard at night and the external doors were locked to prevent unauthorised entry.
- There were computers for staff to carry out e-learning.
- Oxygen cylinders were secured to walls for easy and safe access. We checked six cylinders and they were all in date and safely stored.

Brain injury service

- Wards had both shared bays and single rooms. There were single rooms for isolating patients with infectious illnesses, or patients with challenging behaviour. Shared bays were all single sex.
- Each ward had a red emergency bag containing equipment for emergency resuscitation.

Challenging behaviour unit

- There were alarms in patient rooms: a call bell and a panic button. Staff did not carry personal alarms. This meant that they might not always be able to summon help easily in the ward or when outside the ward with a patient.

Mandatory training

- Mandatory training was provided through a combination of e-learning and face to face training. New staff had their mandatory training as part of their induction.
- Existing staff, including bank staff, were alerted to the need to update their mandatory training three months in advance. Compliance was electronically recorded. Mandatory training for agency staff had formerly been the responsibility of the staffing agency, however managers told us there was a plan for agency staff to attend hospital training so they could better meet the specialised needs of the patients. The level of compliance with mandatory training for ward staff was over 90% in all areas except cardio pulmonary resuscitation (CPR) which was 86% in February 2017. The target for compliance with mandatory training was 95%. Additional training sessions on CPR were taking place during the time of the inspection to improve the completion level of training. Therapists in specialist services were 100% compliant with mandatory training. In the long term nursing home only 93% of therapists were up to date with CPR training.
- Training for clinical staff included basic life support, blood monitoring and gastrostomy training. The list of mandatory training which all staff were required to undertake included, cardio-pulmonary resuscitation, the mental capacity act, deprivation of liberty safeguards, fire safety, health, safety and welfare, infection prevention and control and information governance.
- On the challenging behaviour unit, mandatory training for all staff, including domestic staff, included break away techniques in the event of physical assault and aggression prevention. The hospital ran courses monthly. Compliance with break-away training was 81% due to staff turnover.

- Volunteers supporting patients and residents at RHN had one day mandatory induction and annual refresher training covering safeguarding, health and safety, hand hygiene, confidentiality, moving wheelchairs and the art of listening.

Safeguarding

- At the previous inspection, we had concerns regarding the robustness of safeguarding processes and staff understanding of the issues relevant to the RHN's patient group. We found this had improved on this inspection.
- The hospital had an adult safeguarding policy accessible to all staff and a protocol with the local authority. A safeguarding flow chart gave clear guidance on action to be taken in the event of actual or suspected abuse. We saw these in the wards which meant staff had access to this information at all times. The hospital notified CQC of potential safeguarding incidents.
- There was an executive lead for safeguarding is the director of nursing and the operational lead is the head of patient safety and quality. There was also a trustee champion for safeguarding.
- The director of nursing was setting up a safeguarding committee, which was further evidence of safeguarding concerns being taken seriously. Managers discussed potential safeguarding incidents at the weekly executive management team meeting. We saw evidence that allegations of abuse were reported to the local authority and actions were put in place to minimise the risk of abuse occurring.
- Safeguarding training in protecting adults from abuse was delivered by e-learning, and additional bespoke training scenarios were used to enhance and test the understanding of HCAs and therapy assistants. Staff told us they attended safeguarding training and records showed 95% of staff were trained in safeguarding to level 1 in line with the trust target. Staff we spoke with demonstrated knowledge of what the signs and symptoms of abuse might be, and the different types of abuse to which patients and residents were vulnerable.
- All clinical staff were trained to level 2 safeguarding, however compliance with training at this level was only 77% compared to the 90% target. Staff explained that they had reviewed the staff needing level 2 training in January 2017 and had increased the numbers needing this level of training. Training sessions were run monthly. All matrons and heads of service were trained to level 3 in line with good practice.
- Staff we spoke with demonstrated knowledge of what the signs and symptoms of abuse might be, and the different types of abuse to which patients and residents were vulnerable.
- The hospital showed us that they had system to monitor disclosure and barring service (DBS) checks that were made for all staff being employed. These were seen to be up to date at the time of inspection. The hospital also carried out checks on volunteers.

Brain injury service

- There were two safeguarding incidents reported within the brain injury service in November 2016. These related to a patient having an infected tracheostomy and PEG site, and a nurse responding negatively to a patient using the call bell. The first was found to be unsubstantiated as the infection has been acquired at the acute hospital.

Medicines management

- RHN used a range of medicines safety indicators to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, medicine security and wastage.
- We saw medicines were stored securely. Medicines requiring cool storage were generally stored appropriately.
- An audit in December 2016 revealed gaps in temperature monitoring of fridges and of the temperature of the room in which they were housed. In response, staff arranged training on the importance of temperature control and action to take when there were temperature deviations. The audit had also indicated a lack of stock rotation of medicines, and inconsistent use of expiry date stickers when medicines were opened. We did not find any out of date medicines on checking medicines in two wards. The temperatures of fridges we checked were within range.
- Controlled drugs (which are medicines liable to be misused and requiring special management in wards) were stored and managed appropriately. The hospital had a valid Home Office licence to stock controlled drugs and stored them in accordance with regulations. We saw evidence that drugs were checked each shift by

two nurses who signed to indicate that the balances were correct. We double checked the recorded balances of controlled drugs against the drugs in the cupboard on one ward and found no discrepancies.

- The accountable officer for controlled drugs attended the local intelligence network (LIN) pharmacy governance meeting to share intelligence about issues arising locally.
- Medicines errors and incidents were reported quarterly to a multidisciplinary team of the medication management committee, which reviewed reported medicines incidents, identified themes and trends and where appropriate, any actions to be taken in response to incidents. In response to several incidents related to insulin, RHN managers had reviewed policies and protocols, streamlined and clarified guidance, appointed a diabetes nurse champion and introduced hypo packs on the ward (to treat a potentially serious condition occurring when a person's blood glucose level has dropped too low). A high number of medicine administration incidents were reported, almost one a day. Records showed the level of medication incidents was discussed at senior management meetings and that medical staff considered it too high, even though medicine incidents were low or, more commonly, no harm. The error level was highlighted in the March 2017 risk and incident report.
- We reviewed five medication charts. They were legible and completed appropriately. Patient allergies were clearly noted on the charts. Reasons were stated when any medicine was not administered and any errors were crossed through and signed. All the medication charts we looked at had been reviewed and signed by a pharmacist.
- The hospital policy was to give oral antibiotics but not intravenous antibiotics. A patient needing intravenous antibiotics would be transferred to hospital. Intravenous (IV) antibiotic administration was under consideration for otherwise stable patients to prevent the distress of hospital transfer for patients and families.
- An antibiotic prescribing audit by the GP in 2016 showed that prescribing followed practice guidelines. A small polypharmacy audit of 20 patients (to review patients taking more than four medicines) showed no medicines needed to be stopped but formulation switches led to savings on the medicine budget.
- Drugs were only prescribed by doctors. There were no Patient Group Directions (PGDs). PGDs are documents permitting the supply of prescription-only medicines (POMs) to groups of patients, without individual prescriptions. We were told the hospital was considering training a small number of senior nurses to be non-medical prescribers.
- Nurses wore 'do not disturb' tabards while they administered medicines to patients in an attempt to reduce the number of medicine administration errors.

Brain injury service and specialist services

- The hospital had an onsite pharmacy for the brain injury service, the ventilator unit and the behaviour unit, which was open five days a week. Senior staff on site had access to emergency drug cupboards out-of-hours. This meant patients had access to medicines when they needed them.
- Pharmacists had adopted the formulary used in the local hospital and community health service which listed medication the pharmacy stocked, with guidance on their prescribing. This helped to promote rational, cost-effective prescribing. Any amendments to formulary required approval from the medicines management committee. There was a pharmacy top-up service for ward stock on the brain injury and specialist wards.
- Pharmacists visited the brain injury service wards each weekday. Their role was to review prescriptions to ensure safe and cost-effective prescribing.
- The hospital had recently introduced a new prescription and medicines administration chart to improve compliance with the standards for prescription documentation.
- We were told antipsychotic prescribing had been reviewed in January 2016, which had led to a reduction in the use of psychotropic (mood stabilising) drugs. However we noted that prescribing was sometimes more common than using behavioural management in response to behavioural incidents. We saw that MDT meetings had begun to review those patients taking four or more events of prescribed drugs, in order to change this culture and to reinforce the use of therapy led management. Staff told us this would require closer working between nurses, healthcare assistants and therapists, but we did not see a plan for this.

Specialist nursing home

- Medicines for specialist nursing home patients were supplied by prescription from a local retail pharmacy. Pharmacist's twice weekly visits to these wards reviewed prescription charts to check safe prescribing. They did not check patients own medicines.
- An audit of wastage in the specialist nursing home showed a high level of wastage from discontinued and expired drugs, valued at over £5000.
- Three relatives mentioned there was not always agreement between consultants and the GP on changes to medication, and that medical staff did not always take account of relatives' observations of the impact of medication on their family member.

Records

- Records were mainly paper based. Patients had two sets of records, one with their medical records and the other for their observations. Observation charts included, activities of daily living, fluid balance charts, blood glucose, catheter care and bladder and bowels recording. Of the twenty sets of records we checked most were signed and dated, but fluid charts were not routinely totalled.
- In two sets of patient notes on one ward, the feeding regime was dated 2014 and the guidelines for optimising safety when eating non-recommended foods was almost a year old. This meant there was a risk that potential changes in residents' needs over time could have been overlooked, particularly if there had been deterioration in their swallowing ability.
- Patient records were seen to be stored securely on wards, with access by authorised staff only, in line with the hospital's health record management policy. We reviewed the policy and process for subject access to health records which met the requirements of the data protection act 1998.
- Daily patient notes were not always contemporaneous. The NMC Code of Practice for professional standards of behaviour for nurses and midwives states staff should record information on patient care and treatment at the time of the event or as soon afterwards as is possible to provide a chronological and accurate record of events. There was a risk that records written at the end of the shift might omit relevant information which staff had forgotten to record.
- There was a lack of consistency in record completion between wards. The records on the challenging behaviour unit and BIS were generally of a higher standard than those in the nursing home. A unified patient records committee was working to achieve standardisation, and we saw evidence of improvement, but more work was needed to ensure standardisation across the hospital. A clinical records audit in January 2017 highlighted issues such as signatures without printed names alongside (31% did not meet this), the named individual responsible for the care plan was not identified (73%) and incorrect filing (85%). We saw an action plan from April 2017 (after our inspection) to improve consistency.

Brain injury service

- Records we looked at reflected the standards of The British Society of Rehabilitation Medicine (BSRM) that each patient should have a timed set of outcome goals, coordinated by the Multi-Disciplinary Team (MDT) involving their family We saw evidence in the notes of short and long-term goal setting from the MDT ward round and reviews of these at the six to eight weekly MDT meeting, when staff discussed the treatment goals with patient and relatives.

Challenging behaviour unit

- We reviewed good quality records in Wolfson and Wellesley Wards. All pages were numbered, and documents were chronologically ordered. There were different coloured notes to distinguish therapist input, and amendments were initialled.

Specialist nursing home and wards for people with Huntington's disease

- The quality of records in the nursing home was of a lower standard. For example, we reviewed and random sample of six sets of patient notes on Chatsworth Ward. We would expect all records to specify the level of cognition and decision-making capacity, and how to support communication. This was not what we found. In the sample we looked at progress notes were not always numbered or chronological, and there was no list of names and signatures on the file, so it was not always clear who had added notes. Old notes had not been archived, simply crossed through, which was not good practice.

- All residents had GP records and some residents who were under the care of a consultant also had consultant records. We noted there was medical history at admission, power of attorney information and "All about me" information in resident's notes.

Assessing and Responding to patient risk

- Some patients and residents were at risk of choking, and of aspiration pneumonia which would necessitate their admission to an acute hospital. Speech and language therapists had completed risk assessments to manage food and drink for them, specifying modified textures. We observed mealtimes on some wards and observed not all staff followed the instructions carefully. Few staff at ward level involved in supporting patients with eating and drinking understood the seriousness of this risk. Staff said they had limited training on dysphagia, and we saw this had been a theme of incidents. There were no dysphagia trained nurses. The provider told us following the inspection that ward nurses would provide immediate support. However this was not what we observed. The provider told us, following the inspection, that they had run a rolling programme of dysphagia training between March 2016 and February 2017 to help mitigate the risk of patients and residents choking. They sent us specific risk management plans for weekends and bank holidays.
- Staff did not monitor patients' fluid balances systematically as we found no charts where scores had been added up in any of the wards during our inspection despite recording some of the information needed to do this. Achieving optimal hydration is an essential part of holistic patient care. Two relatives spoke of their concerns that their family members might not be receiving the required daily amount of fluid.
- We saw patients were risk-assessed using nationally validated tools. For example, staff assessed the risk of malnutrition using the Malnutrition Universal Screening Tools (MUST) tool. We saw patient risk assessments were completed, dated and signed.
- Risk assessments were completed for moving and handling for people who required equipment and staff to support them to move and transfer, or had risk of skin damage from pressure sores. We found some moving and handling assessments, including the use of hoists, and other assessments on the long term care wards had not been reviewed for more than a year. During this time a resident's needs might have changed and thereby be at risk of harm if assessments were not updated.
- Nurses assessed the risk of pressure damage using the Waterlow scoring tool. Staff told us they monitored patient pressure areas daily, checked them for redness/ soreness, changed the patient's position regularly and nursed them on pressure relieving mattresses as necessary. We observed staff changing patients positions both day and night. A tissue viability nurse visited the wards throughout the hospital regularly to advise on the management of pressure ulcers.
- Since October 2016, staff had used the national early warning scoring (NEWS). NEWS is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled staff to identify patients who were becoming increasingly unwell. Many patients and residents, particularly those with prolonged disorders of consciousness had a regular pattern of observations that did not fit into conventional early warning scoring system, so they had individualised charts that reflected their specific baseline scores, for example lower than average blood pressure. NEWS scores were correctly recorded on charts were reviewed.
- An audit of the NEWS system in February 2017 had shown many staff were not completing this properly, for example not increasing the frequency of observations or documenting clinical interventions when a NEWS score was a trigger for action. Extra training had been arranged for nurses. A re-audit was planned for March 2017 aiming for 100% compliance. Although the result was not available at the time of the inspection, four nurses we spoke with about this showed good understanding of the process.
- There was a protocol with the nearby tertiary hospital transferring patients in an emergency, and we saw evidence of meetings to ensure the process worked smoothly. If a transfer was necessary a doctor from RHN would contact the bleep holder at the acute hospital. NEWS and drug charts were transferred with the patient, which ensured the receiving hospital had the information they needed to provide safe care. Data showed 208 patients were transferred during the reporting period October 2015 to September 2016

Good

Long term conditions

- Staff we spoke with were aware of the standard sepsis 6 bundle, but were not trained to manage sepsis. They would call 999 if they suspected a patient had sepsis, as they were not an acute hospital.
- Records showed staff were trained in basic life support and the use of an automated external defibrillator (AED). Managers told us senior clinical staff had enhanced life support training, which included scenario training, but we did not test this. In the event of an incident out-of-hours, staff would bleep the medical team. If more than basic first aid was needed, the patient would be taken by ambulance to a hospital emergency department.
- Handover took place at each shift change and covered set topics such as allergy status, resuscitation status, infection issues and any 'at risk' patients.
- There were patients with tracheostomies in many wards in the hospital. We observed staff complying with the local policy in ensuring that all such patients had regular observations of their vital signs, and standard checks on position, secure tape, correctly- sized suction equipment and adaptors.

Nurse staffing

- The head of nursing and the matrons had reviewed the nursing establishment during the summer of 2016 and reviewed this every six months. They consulted ward managers to ensure staffing ratios were appropriate and complied with safe staffing requirements of each ward. We saw there were rarely issues with short staffing and no incidents had been reported in relation to staffing numbers, although there was sometimes a very high proportion of agency staff. The provider told us following the inspection that most agency nurses worked regularly at the hospital. Rotas showed overall staffing numbers generally matched agreed establishment. We observed ward activities and nurses did not appear rushed.
- Staff used patient handover at shift changes primarily to transfer health information, such as changes in skin condition or medicine changes, to ensure patients were safe. The handover was also an opportunity to pass on information about any training or learning from incidents. There was little information shared about other elements of the person's day, such as activities or visitors,
- Recruitment and retention of permanent staff remained a challenge despite recruitment drives for HCAs and planned nurse recruitment fair. It was clear from minutes of meetings, and from what staff and relatives told us, that the level of agency use was high at about 27% which was higher than the rate at local hospitals. However, a proportion of the agency staff worked regularly at the hospital and knew the routines and the patients well. We confirmed this by speaking with several regular agency staff
- We had concerns in the previous inspection about heavy reliance on agency nurses and healthcare assistants, and the competence of some staff. We saw a high number of agency nurses on the evening we inspected in April 2017. Relatives told us that at weekends, there were often more agency staff than permanent staff and we observed this to be the case with nurses on a night shift.
- Managers had taken steps to ensure agency nurses had the right competencies. Where possible, managers block-booked good agency staff who had worked at the hospital before, to ensure competent care and continuity for patients. Agency staff wore badges to indicate their competencies, but staff said sometimes the agency staff had little practical experience of competencies such as suctioning patients. The hospital was introducing joint mandatory training of permanent and agency staff to improve competencies of all staff.
- Where possible, senior staff tried to ensure no group of patients were left without a member of permanent staff and a new agency nurse would be paired up with a permanent registered nurse. Ward managers told us they were responsible for the orientation of agency staff and checking their skills. We spoke with four agency staff who confirmed they had had an orientation, and said that the skills passport on their badges confirmed their skills.
- The hospital employed a number of bank nurses who filled shifts on a planned or ad hoc basis. Staff told us some bank staff had formerly been employees and others were good quality agency staff who managers had encouraged to join the bank.
- Medical staff and patients' relatives told us they felt there were usually enough nurses on duty to meet patients' needs.
- Matrons and the head of nursing reviewed staffing levels for patient and resident acuity every day and moved staff as necessary after risk assessments. The site manager assumed this role at night.

- The on-call clinical manager, a senior nurse, oversaw the hospital at night. This senior nurse was supported by a peripatetic nurse who supported ward nurses as needed during the night, for example if an agency staff member was not paired with a permanent member of staff, as happened on our unannounced night visit. The second nurse was also a practice education facilitator.
- The hospital employed clinical nurse specialists for infection control, tissue viability, respiratory, nutrition and had access to palliative care nurses from a hospice.
- The RHN policy was to have one registered nurse for every three patients with a tracheostomy.

Brain injury service

- We saw evidence that the Brain injury service took into account of the British Society of Rehabilitation medicine 'Specialised Neurorehabilitation Service Standards' 2015 to ensure safe staffing. They were working towards achieving full compliance with the NICE guidance and NHSE's expectations relating to safer staffing. However, they did not meet the recommendation that one-third of nurses should have rehabilitation or mental health training.
- Staff told us there were always enough staff to care for patients.
- Most nursing and healthcare assistant staff rotated between day and night shifts.
- The brain injury service wards offered placements to student nurses. Staff told us they had good relations with link tutors and universities and had an increasing number of requests from students to return as qualified nurses. There was a preceptorship programme for newly qualified nurses.

Specialist Unit and Nursing Home

- The Specialist Services and Nursing Home team told us nursing recruitment was a challenge.
- Since the previous inspection, where we had concerns about staffing on the ventilator unit, the staff establishment had increased. There were five RN and five HCA in the morning; five RN and four HCAs in the afternoon, and three RN and three HCA at night for 16 patients. The issue of staff retention and high use of agency staff remained. The target was 20% agency staff but the actual agency use was 28%. Senior staff were concerned about this and seeking to recruit more permanent staff.

Medical staffing

- All medical staff except the GP were directly employed by the hospital. The medical staffing had increased by one post since the previous inspection and there were no vacancies. There were six full time speciality doctors and four full time rehabilitation consultants. We were told that locums were rarely used but could be employed to cover periods of absence, but there were none during our inspection.
- Permanent medical staff were supplemented by regular contracted visits to specific patients from a respiratory consultant, neurology consultant and other specialists.
- Consultants reviewed patients in the brain injury unit and ventilator unit on ward rounds.
- There was no doctor on site at night. A specialist doctor was on call to both patients and residents and could attend within 30 minutes. There were back up, consultant on call arrangements for the brain injury service, the ventilator unit and the behavioural unit. Staff explained they used a standard form for communicating with 'on call' doctors out of hours, based on the standardised Situation, Background. Assessment, Recommendation (SBAR) communication principles. This technique helped staff structure the communication of important health information efficiently so it was clear why the doctor should attend.

Brain injury service

- Medical cover had been a concern in the previous inspection. We found during this inspection there was a substantive medical director providing clinical leadership throughout the hospital and handovers took place daily.
- A consultant and either one or two specialty doctors covered each ward. All patients in this service were under the care of designated consultants. There were 11 medical staff,
- The brain injury service wards were approved for training rotating trainee doctors in neurology.
- There was a medium term vision to have the hospital on the rotation for junior doctors in the early years of training. The medical director considered this would help keep standards high as the hospital would have to be compliant with educational standards.
- We observed a discussion between nurses at night about whether to call in a doctor for a patient who had

recently returned from hospital but the decision was to continue frequent observations. Doctors told us they visited patients out of hours when necessary and night staff confirmed this.

Specialist services

- Patients in the ventilator unit and the behavioural unit were under the care of designated consultants, and one or two specialty doctors, depending on the complexity of the patient.
- In the behaviour unit, a neuropsychiatry consultant attended the wards for one half day a week to assess patients and attend MDT meetings with therapists and nurses. This arrangement had started in the autumn 2016 and we were told following the inspection that an increase in neuropsychiatric input was under consideration.

Nursing home

- Residents of the Specialist Nursing Home and the patients with Huntingdon's disease were under the care of a GP, with additional support from a neuro-rehabilitation consultant.
- There were no ward rounds in the nursing home.
- A GP, under contract to the hospital, or a GP deputising service was present on site daily on weekdays and visited patients on wards as well as seeing those referred to the GP surgery. Out of hours there was a GP on call for residents, although the specialist hospital doctor on call was the first doctor nurses would call.

Therapy staffing

- The hospital had a large therapy team including physiotherapists, occupational therapists (OTs), dietitians, speech and language therapists (SALT), clinical psychologists and music therapists. There were some locum and bank therapists. The therapists were well-integrated into the MDT. The therapy professional lead attended Executive team meetings to represent their interests.
- The therapy staffing levels were aligned to the needs of the patients and residents in each service area.
- SALT staff worked across the hospital.
- Physiotherapists visited patients on the ventilator unit during the day if staff reported that any patients had experienced respiratory problems during the night. Each patient had a cough assist machine which had reduced incidents of night time distress. The machines had also reduced medication and psychological concerns of some patients so improving their quality of life.

Brain Injury service

- Brain Injury Service therapy staffing levels were based on the British Society of Rehabilitation Medicine (BSRM) Guidelines. RHN reviewed staffing levels against these guidelines annually as part of the annual contracting process.
- Therapy staffing could be flexed across the three wards depending on occupancy and clinical need. There were 9.42 whole-time equivalent (WTE) OTs, nine WTE physiotherapists, 4 WTE clinical psychologists, 5.4 WTE speech and language therapists, 2.1 WTE dietitians, and 13.5 WTE therapy assistants. There were also 3.8 WTE social workers.
- Not all patients on Drapers ward were on active therapy programmes at the time of the inspection.

Specialist Nursing Home

- The long term Specialist Nursing Home followed the specific BSRM Guidance in providing care for people with complex neurological disability. This guidance did not specify staffing numbers. An annual review of patient complexity scores aligned the therapy staffing to patient acuity.
- The ratio of therapists to residents was lower than in the main hospital, for example there was one physiotherapist for 36 patients. Physiotherapy was to maintain flexibility rather than for rehabilitation.
- Nursing home patients were reviewed by a physiotherapist every three weeks.

Major incident plan

- The hospital had revised a major incident plan in October 2015 and was due for review in October 2017. Work had started on revising this to ensure there was business continuity in the event of an emergency, or incident such as fire or flooding. An interim business manager was coordinating this.
- Visitors signed in at reception, so there was a record of who was in the building in case evacuation was necessary in an emergency.
- An external fire risk assessment had been carried out to identify and minimise risks. Table top fire drills were

carried out six monthly. Managers told us they had recently reviewed the daytime evacuation process, when most patients were not in bed, but would need to be evacuated in wheelchairs.
- In the case of electrical shutdown, the hospital had its own generator and we saw weekly checks were made of fuel and oil to ensure it was ready for immediate use.

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

Good

We rated effective as good.

Evidence-based care and treatment

- We checked nine policies and saw they were based on NICE/Royal College guidelines and we observed care was based on best practice.
- All patients had 24 hour photographic position guidelines in bed folders and care plans. This enabled the staff to be safe in their moving and handling and positioning of the patient. There was also pictorial guidance for wheelchair and splints.
- There was a weekly tone clinic (to review patients with an involuntary increase in muscle tone (spasticity) following brain injury, producing tightness or stiffness of the limb muscles). Treatment aimed to reduce pain and stiffness. RHN followed the 2009 Royal College of Physicians guidelines for spasticity in adults. The Botox pathway included discussion with the family, which was documented.
- Physiotherapists also used conservative measures, such as positioning, stretching and exercise were also used in spasticity management. A doctor told us RHN used oral medicines for some patients, but side effects such as sedation were a complicating factor in patients with brain injury. Some patients therefore had implanted infusion pumps, small devices surgically implanted under the skin to provide targeted and consistent medication to reduce a specific part of the body. Staff audited compliance with the guidelines of the National Institute for Health and Care Excellence (NICE). We saw the hospital had recently reviewed compliance with NICE guideline 138, Patient experience in adult NHS services, and quality statement 13, End of life care for adults
- The AAC service, a hub for assessing patients and providing electronic assistive technology with complex disabilities, used recognised Therapy Outcome Measures (TOMS) for communication. The team provided the service for inpatients and also in the community.
- The hospital had a protocol for caring for tracheostomy patients. There were 53 tracheostomy patients in different wards. A tracheostomy nurse reviewed all patients at least once a week and referred to national guidance of the national tracheostomy collaborative and the global tracheostomy group. The nurse had access to Fibre optic Endoscopic Evaluation of Swallowing (FEES) on site fortnightly, and to video fluoroscopy at the local tertiary hospital.
- A 2012 audit of patients with a PDOC diagnosis in the Specialist Nursing Home had shown changes in levels of consciousness over time. This led to the Research Team developing a more formal way of tracking this through the development Sensory Modality Assessment and Rehabilitation Technique tracker. From January 2017, all residents with a PDOC diagnosis underwent on-going assessments in line with the PDOC recommendations to measure whether their condition had changed.
- The hospital did not take patients who were sectioned under the mental health act, only those with acquired brain injury or a neurological condition that were medically stable.

Brain injury service

- The brain injury service was a tertiary specialised service and as such followed the standards set out in the NHS England service specification for patients with the most complex neuro-rehabilitation needs with high physical dependency. The unit had two distinct pathways for patients: A Rehabilitation pathway and Prolonged Disorders of Consciousness (PDOC) pathway.
- The brain injury service used national guidelines: Rehabilitation following acquired brain injury and the prolonged disorders of consciousness national clinical guidelines, Royal College of Physicians (RCP) 2013 to ensure safe staffing.
- New admissions to the BIS had a respiratory assessment within 48 hours of admission to create a management plan for respiratory health.
- The service used recognised assessment tools to assess care requirements, and baselines from which to measure progress including the emotion regulation

checklist (ERC), Wessex Head Injury Matrix (WHIM) (communication, attention, social behaviour, concentration, visual awareness, and cognition) to monitor subtle changes in patients in a minimally conscious state and music therapy assessment.
- Staff were using a new outcome measure for patients with PDOC to measure the impact of the specialist programme. The research unit was testing the validity and reliability of this measure.

Challenging behaviour unit

- Therapists used ABC (Antecedent, Behaviour, Consequence) charts to better understand and devise management plans for challenging behaviour. They used Positive Behavioural support (PBS), based upon the principle that, if you can teach someone a more effective and more acceptable behaviour than the challenging one, the challenging behaviour will reduce.
- In practice, some staff said that nurses did not always implement therapists' treatment plans fully.
- We saw that staff completed agitation and arousal charts hourly to record trends, patterns and overall wellness over a period.

Specialist nursing home

- Staff assessed all patients before admission, using a standardised set of indicators and developed MDT care plan for each individual, with input from the patient (where possible) and family.
- Sensory assessments were repeated at appropriate intervals (including for patients with prolonged disorders of consciousness) to identify any changes in awareness and care was adjusted accordingly. Health and care passports were updated after each review.
- Since January 2017, reviews of residents were to be annual and would include bed positioning, food mats, wheelchair needs. If staff identified changes from nil awareness of self to fluctuating awareness they could review stimulation and update the resident's passport. Where possible families were involved in reviews. Not every patient had all assessments updated at their time of our inspection in March 2017.

Nutrition and hydration

- We saw nutrition care plans for the 180 patients fed enterally because they had significant swallowing difficulties. Enteral feeding is a way of delivering nutrition directly to the stomach or small intestine). The nutritional plans were developed in conjunction with a dietitian and speech and language therapist (SALT). A few patients and residents were able to eat a small amount of food orally with their diet supplemented by enteral feeding. We saw there were a number of incidents relating to enteral feeding which, although they were classified as causing no harm, appeared to indicate a training need. The risk and incident report for March 2017 highlighted gastrostomy care and feeding as risks. Following the inspection the provider told us a gastrostomy clinical nurse specialist had taken up post just after our inspection to support all care relating to enteral feeding.
- Patient records showed that staff used the Malnutrition Universal Screening Tool (MUST) tool to assess patient's nutritional status. Dietitians weighed residents monthly unless concerns about malnutrition indicated more frequent weighing.
- Many patients and residents had meal mats, which had pictures of the type of meal for the person, explained the diet and fluids to serve the patient, the position to place the patient in when they were eating, the level of help required, and the communication and swallowing strategies required.

Brain injury service

- On Drapers Ward we noted meal mats and adaptive cutlery were generally used well, although we observed an instance of a patient coughing on dry food on four occasions during a meal and a lack of staff reaction to this until we drew attention to the issue.
- Medical staff told us there was now better liaison with the local acute trust for when patients required PEG tube changes.

Challenging behaviour unit

- We saw poor practice where a student was asked to support a patient with eating and drinking with no training and unsupervised, with no support from permanent staff about how and why to follow the guidance on the meal mat. In addition, the patient's drink was the wrong consistency, because it was not mixed according to guidelines. There was therefore a risk that the patient might have inhaled the drink into their lungs, potentially causing infection and breathing

problems. In addition, staff on duty did not seem to know how to reduce the resident's aggression caused by the delay in having a drink. We escalated this incident to senior staff on site at the time.

Specialist nursing home

- Agency healthcare assistants we spoke with had not received training on supporting patients with feeding. They had poor understanding of the reasons for the meal mat guidelines and the consequences of not following them.

Pain relief

- For patients who were able to verbally report their pain, staff used a 1-10 pain scale, which was part of the NEWS assessment.
- When patients were not able to communicate, pain was assessed from movement or facial expression. A nurse explained that staff used the Visual Analogue Scale (VAS) Pain score to review levels of pain. This measuring tool assessed subjective characteristics that could not be directly measured. For example, the nurse said they would look for patients frowning, wincing or guarding painful limbs. These kinds of behaviour indicated people needed their prescribed pain relief.
- A palliative care consultant visited the hospital half a day a month and palliative care nurses from a local hospice visited the hospital as needed. A Clinical Nurse Specialist provided symptom control advice and syringe drivers (to help control pain by delivering a steady flow of liquid medication through a continuous injection under the skin) were available.

Patient outcomes

- RHN also used national outcome measures to assess patients and monitor progress. The supplied data to the main national audit collated by the UK rehabilitation collaborative (UKROC) which analyses data from the most specialist units. There is no national comparator for RHN because of the profound disorders of consciousness of many patients.
- RHN was a member of the Independent Neuro-rehabilitation Providers Alliance which provided a forum for debate on issues such as outcome measurements.
- Speech and language therapists used Tracheostomy Therapy Outcome measures (TOMS).
- A tone (muscle rigidity) audit in two of the BIS wards in October 2016 showed staff were meeting good practice guidelines for the tone pathway.
- Most patients in the hospital were long term residents. The hospital did not offer slow stream rehabilitation as some other services did. The service offered maintenance therapy to manage physical disability, management of spasticity and regular repositioning to prevent pressure sores. The nursing home did not benchmark with other providers,

Brain injury service

- Staff assessed patients before admission using the Patient Categorisation Tool as required by NHS England of all tertiary neuro-rehabilitation providers.
- The brain injury service submitted monthly data to the (UKROC). These indicated that most patients admitted to RHN were at a significantly higher complexity level than those admitted to other providers. Many patients had minimal or no awareness (94% of patients compared to an average for other providers of 74%).
- We were told and saw from patient records that after admission each brain injury service patient had outcomes and goals set as part of their individual programme. The outcome measures used were standard measures. The national UKROC data showed evidence of rehabilitation gain on cognitive and motor scores on discharge compared to scores on admission. However, the gains were smaller than in other providers taking the same broad category of patient because they had such profound disturbances of consciousness on admission. Clinicians recognised that the standard measures were not sufficiently sensitive for such a specialist group of patients who would almost all continue to need a high level of ongoing care. Research staff at RHN were working to find ways of demonstrating the impact of interventions on therapeutic outcomes. Receptivity to music was one outcome under investigation for measuring change in awareness.
- Thirteen patients in the brain injury service had tracheostomies. The hospital was proud that two patients previously diagnosed as needing permanent tracheostomies were now able to breathe independently.

Specialist services

- Staff used the recognised Health of the Nation Outcome Scale, (HoNOS) a measure of the health and social functioning of people with severe mental illness resulting from Acquired Brain Injury, every quarter to assess patients in the challenging behaviour unit.

Specialist nursing home

- Within the long term care service the residents did not have specific goals. Therapists reviewed residents twice a year using the Extended Rehabilitation Complexity Scale to assess the level of nursing care residents needed, and note any changes in their conditions. Staff also undertook a yearly multi-disciplinary review and reported to the funding authority for each patient and resident. For most people these demonstrated an avoidance of deterioration.

Competent staff

- All staff should have an annual appraisal. Although 91% of staff on the BIS had had an appraisal of their performance in the 12 months before the inspection, the percentages were lower in the other two services: 67% of staff in specialist services and 78% in the nursing home. This was worse than the target of 95%. The provider told us following the inspection that the data they submitted before the inspection was incorrect. They stated that all medical staff were up to date with an appraisal on their performance.
- Supervision for senior therapists was provided by an external company. Both Heads of Therapies said they were happy with the supervision they had received. Other therapy supervision was in house.
- Ward managers oversaw nurse supervision. Staff we spoke with said supervision was every six months, in line with the policy and confirmed supervision took place.
- RHN had a dedicated Learning and Development team which focused mainly on nurses but also AHPs and non-clinical staff.
- New clinical staff had a four day induction. They were supernumerary for two weeks, during which time they demonstrated competencies in key areas relevant to their role. New staff were allocated a buddy to support them.
- Most nurses were not trained in rehabilitation. However, the hospital was piloting a new one year 'Putney Nurse' programme covering additional clinical nursing skills associated with rehabilitation.
- The learning and development team supported nurses with revalidation through workshops and offering staff a sample portfolio. Ward managers were encouraged to discuss revalidation at supervision and staff we spoke with confirmed they had these discussions. A lead for allied health professionals supported therapists with revalidation.
- Staff from two external specialist respiratory units supported staff working on the ventilator unit. All nurses were required to be tracheostomy competent although in practice we observed some agency staff did not appear confident in this area. A specialist tracheostomy nurse taught all staff on a competency based programme and also trained family members for patients before discharge, and provided daily support for the ventilation unit. Three nurses were undertaking a university accredited ventilator/advanced respiratory course.
- From April 2017 agency nurses would have access to internal training and there were arrangements for their agency to pay for this.
- A rolling practice development programme was held for nursing staff covering items such as early detection of the deteriorating patient, response to cardiac arrest and Immediate Life Support. The equivalent short, compulsory training sessions for day staff took place at lunch times known as 'lunch time takeaways'.
- RHN followed national guidance for hydrotherapy health and safety training for staff. Ten staff had undertaken the Foundation level course.
- Assistant therapists had access to training for bands 2 and 3, NVQ level 3. Training was in house and non-clinical staff had access to training under the Qualifications and Credit Framework (QCF). The hospital was an accredited QCF centre. There had been less training for HCAs on wards. The learning and development team planned to introduce more training opportunities during 2017.
- All staff working in the challenging behaviour unit were trained in Prevention Management of Violence and Aggression (PMVA).
- We had concerns about the amount of training on communication given the complex range of needs of patients in the hospital. Therapists said they had 45 minutes communication training on induction and an

hour every three months. There was no training on communication for domestic staff. Some staff we spoke with were unaware that patients and residents had communication passports on their wheelchairs.
- All staff expected to drive hospital vehicles had a pre-employment DVLA check, reviewed annually by the Head of Service. All drivers were up to date with their Minibus Driver awareness training.

Multidisciplinary working

- Staff from a range of disciplines contributed to patients' care, particularly therapy staff. Therapists considered joint assessment and planning had improved during the previous year when the therapist moved into shared office accommodation. We saw evidence of MDT assessment and care in patient care plans and of MDT meetings.
- Doctors from other disciplines not represented by RHN doctors also contributed to patient care. Patients also had access to psychologists.
- Records showed that staff undertook detailed multi-professional assessments before admission, to ensure the patient or resident's needs could be met at the hospital.
- There were arrangements for transferring patients to acute NHS hospitals for specific procedures such as preparation for enteral feeding, and these referrals followed standard pathways.

Brain injury service

- Patients had continued access to acute medical and surgical teams during their early specialist rehabilitation. Patient notes evidenced MDT assessment and continued MDT care.
- On Drapers rehabilitation ward, a twice weekly MDT case review took place, involving nurses, doctors, psychologist and all therapists. Therapists we spoke with considered joint working and communication had improved over the past year.
- Staff told us patients and their families were involved in the goal setting process and their wishes and opinions were included in the goals set, however not all family members considered they were adequately involved.

Specialist nursing home

- MDT meetings took place fortnightly for long term residents.
- There were twice daily handovers at shift change where nurses and healthcare assistants discussed the care given during the previous shift and any issues or concerns.

Seven day services

- Doctors, therapists and specialist nurses worked five days a week. A patient deteriorating significantly, whether during the day or out of hours would be transferred to an acute hospital as an emergency as RHN was not an acute hospital.
- There were diagnostic facilities such as X-ray and ultrasound on site, as well as a pharmacy five days a week.
- Consideration had been given to the need for a respiratory physiotherapist at weekends. A four week audit of patients indicated that a respiratory physiotherapist was only essential on long weekends, so a respiratory physiotherapist was provided on Friday and Sunday on bank holiday weekends for any patient or resident needing support. The provider told us following the inspection that this service was available to any patient or resident needing support.
- There were no therapy services at weekends.

Brain injury service

- Formal therapy took place only five days a week. However therapists told us they worked with nursing staff and families to encourage them to continue some therapy activities at weekends. Staff said leisure time was also therapeutic.
- No doctors or consultants were on site at weekends but a consultant was always on call. Ward staff we asked about this told us that they were always able to reach a doctor when needed.

Access to information

- Staff shared relevant health records with health and social services, and with clinical commissioning groups funding patients as required. Residents at RHN were registered with a GP through the hospital's arrangements.
- If a health record was temporarily removed from a ward to support patient care e.g. a dentist appointment, there was a sign out procedure and tracking procedure. .
- Discharge arrangements were comprehensive and included preparing a discharge report including medical and an MDT summary and an individual management booklet about the person's day to day care needs so

that the new carer would understand their care needs. The level of dependency of patients meant that no patient was discharged without a proper handover to the patient's home or to residential care. Original care and treatment records from RHN were retained and archived at an external secure storage facility in case there was a need to refer to these at a future date.

- We checked 18 hospital policies. All policies except one were in date and referenced national guidelines, such as from NICE and the General Medical Council. Staff we spoke with knew where to find the policies and gave us examples of when they would refer to them.
- Patient records were available through both paper and electronic notes systems. Staff had the required access to these including results of diagnostics and imaging.

Consent, MHA and DoLS

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do this for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so. When people are unable to make particular decisions, any decisions made on their behalf must be in their best interests, the least restrictive possible, and legally authorised under the MCA. Patients' and residents' capacity was assessed, although sometimes there was no record of their capacity in relation to the full range of decision-making. The result was that not all ward staff understood that they should do as much as possible to support people who had some capacity to give consent and make choices.
- The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005 and allow restraint and restrictions to be used, but only if they are in a person's best interests. The lack of applications for Deprivation of Liberty Safeguards had been a concern at the June 2015 inspection, but we found at this inspection that relevant applications had been made.
- There were up to date records of the status of the patient in relation to DoLS authorisations. At the time of the inspection 48 patients and residents were assessed as having capacity to consent to their placement at RHN; 171 patients had their liberty restrained in some way; 96 patients had a DoLS authorisation and a further 71 people were awaiting assessment by the relevant local authority . Of these, three patients had assessments completed, but RHN was awaiting formal feedback. Forty-four patients and residents had a deputy appointed by the Court of Protection with powers to take decisions about the service that RHN provided, and nine had given another person valid and active lasting powers of attorney with authority to take decisions.
- An electronic database recorded patients' formal capacity assessments, information about IMCAs, Lasting Power of Attorney, Court Appointed Deputy, DoLS, Best interest decisions and Advance Decisions. When an application for DoLS was approved, an automatic alert notified the ward and the head of patient safety and quality, and CQC were then notified.
- Nurses on the behaviour unit said in the event of patients with behaviours that challenged, they would contact the neuro-psychiatrist to review medication. They had never had to restrain patients. They could call the Mental Health Team to assess the patient. Health care assistants were employed for patients needing one to one care. This applied to patients on Wellesley and Hunter Wards.
- A summary sheet at the front of each patient or resident's medical records provided evidence of a review of mental capacity. However at ward level, particularly in the nursing home, staff had interpreted a DoLS authorisation as giving authority for a whole treatment plan. Authorisation to deprive someone of their liberty does not include authorisation to give care and/or treatment. If lack of capacity is established, it is still important to involve the person as far as possible in making decisions, making every effort to find ways of communicating with someone before deciding they lack capacity to make a decision based solely on their inability to communicate.
- RHN had an End of Life care policy although the arrangements were under review. The ethics committee had been set up to review advance decisions and Do Not Attempt Cardio-pulmonary resuscitation (DNACPR) checklists which would become part of the discussion in best interests review meetings. Clinical staff sought to facilitate forward planning, involving families as recommended in our previous report. They reassured families that a decision not to resuscitate in the event of cardiac arrest did not mean reduced access to treatment.
- We found that 'do not attempt cardio-pulmonary resuscitation' (DNACPR) records were signed and dated.

Good

Long term conditions

- We found very few patients who had capacity to do so, had advanced care plans in place. However, putting advanced care plans into place is considered best practice.

Brain injury service

- We observed appropriate use and documentation of MCA, including best interest decision-making, use of different formats of information to aid patient consent and evidence that fluctuations in capacity were assessed in a timely way. Patients on Clifden Ward were nursed with bed rails for their own safety, with evidence that patients had their mental capacity assessed and recorded, before making the decision about bed rails on their behalf.

Specialist services

- Staff showed awareness of people's right to consent to care and treatment and asked patients and residents appropriately. Where a person was cognitively impaired, staff followed the care plan for that person.
- Of the notes we reviewed for best interests decisions we found all but one in patients' notes. In the case where this was missing, staff told us they followed the restrictions they knew to be in the authorisation, and understood that restriction was not needed when the patient was calm.

Nursing home

- Patient notes did not always contain information about best interests assessments or how to how to help patients express their wishes. Some staff were unaware of the need for reasonable adjustments to help decision-making, and they referred to patients as either having capacity or not. We reviewed a small random sample of care plans and found notes did not always make it clear that capacity assessments should be decision-specific or specify the level of cognition or decision making capacity in relation to different types of decision.
- However, in some areas we observed examples of staff using communication equipment to support patients with difficulty in verbalising their choices, to give them the opportunity to consent.

Are long term conditions caring?

Good

We rated caring as good.

Compassionate care

- Although many of the patients and residents had limited verbal communication, those we spoke to responded positively about staff.
- Patients and residents looked well cared for and family members said most staff treated their relatives with kindness and compassion. We saw therapists display sensitivity to patients' needs, for example, delaying planned therapy when a patient was tired, and agreeing to return later.
- The leisure team tailored the extensive range of activities to patients and residents' interests. This could include outings to football, theatre or pub as well as day to day activities. Families who visited regularly were involved routinely in the day-to-day experience of residents, assisting staff to personalise the care given.
- However, there was some inconsistency in the care that we observed, which both relatives and some staff mentioned to us. We observed some staff to be task-oriented rather than taking an overview of every patient's actual or potential needs. A patient told us night staff could be abrupt, for example asking them not to use their call bell at night.
- We reviewed results from the hospitals most recent survey of patients and relatives views. One relative of a patient in the brain injury service commented that all staff were polite, friendly and always had a 'genuine smile'. Families' perceptions of the specialist nursing home were less favourable than perceptions of the brain injury service or specialist services.

Understanding and involvement of patients and those close to them

- In the brain injury service there was more involvement of families and a higher level of personalisation of care compared to some similar units we had inspected.
- People living at RNH and some relatives told us they were involved in planning care. A few relatives said they were not always invited to contribute a suggestion and felt staff disregarded their views when they made observations about their relatives' well-being.

- We saw staff support patients to make choices about the clothes they wore and to choose social activities, although some staff understood better than others how to help people make choices.
- Care plans covered information to promote patients and residents' dignity and privacy. Not every patient had their own room, but where patients or residents were in shared areas, we observed staff taking care taken to protect privacy and dignity. We saw staff knock on doors of people's rooms when they knew the person could answer them, and people were properly dressed around the hospital and appropriately covered when being taken to shower.
- In communal areas, in parts of the specialist nursing home, we noted some staff rarely interacted with residents as they carried out their tasks. We reviewed the results of a survey of communicating with patients with complex communication needs which indicated there was room for improvement on staff understanding of the importance of communication and having time to communicate.
- The hospital had initiated a project to improve support for relatives, led by a psychologist. There were already forms of practical support such as a subsidised restaurant facility, free refreshments on wards and accommodation in a residential lodge for a fee.
- The passport 'All about me' was useful to staff in helping them meet people's personal, cultural, social and religious needs, and we saw that there was provision for people to maintain their faith and to attend activities that chimed with their interests.

Brain injury service

- Family members were encouraged to visit patients and we saw staff asking some relatives how they would like to be involved in the patients' care.
- The ward sister on Devonshire Ward had introduced training in specific caring skills for family members to help them care for their loved one. This began with mouth care and later progressed to suctioning, tracheostomy care and PEG care. However, support for family members' involvement in caring was not consistent across the unit. Two relatives of another patient on Devonshire Ward told us staff stopped them giving personal care, and they were upset by this.
- Each patient had a named nurse, who was the contact relatives could speak to on any given day. They also had a keyworker whose coordinated care. The names were displayed on the wall at the patient's bedside. The keyworker was involved in formal meetings with the family a month after admission. Therapists were piloting goal planning so the family could see progress, and the hospital had received good feedback from families and patients. In the previous inspection, we had considered goal planning was not individualised, but we saw evidence of improvement on this inspection.

Specialist nursing home

- Staff said there were fewer complaints from families about lack of intensive therapy in the long term care wards after more discussion and explanation about how much improvement was realistic.

Emotional support

- The chaplaincy service provided outstanding emotional support to patients, residents, families and staff, to those of all faiths and of none. The chaplain and assistant sought to provide support with the emotional impact of trauma and ill health. Families spoke very highly of the support they had from the chaplain.
- A high proportion of long term residents attended the weekly non-denominational service. There were Muslim prayers on Fridays, and the chaplain could arrange access to faith leaders in other religions to meet patients and residents' needs.
- The Leisure and Family Service organised volunteers to assist patients and residents in groups and individual activities. Leisure staff and volunteers sought to create a community and family ethos. Relatives of patients and residents told us they supported each other where they had concerns and found their own informal network of relatives useful.
- The chaplain supported staff and families as well as patients. Many long term residents ultimately died at RHN. He wrote personally in the event of bereavement and sent cards to family and staff members for significant events. He performed many funerals at the RHN, both secular and religious and these were personalised.

Are long term conditions responsive to people's needs?

Good

Long term conditions

(for example, to feedback?)

Good

We rated responsive as good.

Service planning and delivery to meet the needs of people

- The hospital received patients from a wide area. For the brain injury service there was an element of regional planning. The hospital used the NHS England online waiting list through which all providers in London who could meet the needs of patients with severe brain injury shared waiting times and discussed possible admissions to other units to avoid extended waits. A referrals team and a consultant screened referrals. Commissioners were closely involved because they had to agree funding before admission. There was a meeting with commissioners six weeks after admission to review a patient's progress.
- For patients in the long term nursing home an annual meeting with the multi-disciplinary team, resident, family and the relevant clinical commissioners provided the opportunity to discuss the on-going needs including therapy and nursing needs and leisure.
- In our June 2015 inspection, we had concerns that some of the wards were not very homely. In this inspection we saw the hospital had made improvements. A five year capital improvement plan focussed on improving the environments for residents and patients. There were short term plans to refurbish Evitt and Drapers wards which looked clinical and in need of updating.
- RHN had spacious communal rooms for large scale activities, such as films and concerts, a café for patients and relatives. To support more individual activities, there was a CD Library, computer room, a kitchen for baking as a sensory experience, and hairdressing and podiatry. A smoking room was available for residents on the ground floor. A state of the art physiotherapy gym was planned for end 2017 and had staff input to the design. This would replace a functional and old fashioned gym space.
- A large art room was available for higher functioning patients, and an 'art on wheels' service took art to wards, on a four week rotation, for those unable to visit the art room. Art work by residents was on display.
- The Sanctuary was a quiet space that patients and residents could use for reflection or prayer. It had large windows and no clock, with prayer mats, literature, candles and music choices. Extensive gardens open every day for patients, residents and families. However, patients on Wellesley Ward had poor access to the grounds and we were told residents did not often leave the ward.
- Alternative therapies were available for appropriate residents at a subsidised rate. These included massage, reflexology, aromatherapy and acupuncture. Pet therapy was free.
- 98% of patients and residents were wheelchair dependent. The service was able to provide adapted wheelchairs within 48 hours of admission. RHN owned wheelchair adapted vehicles, to support patients' access activities outside the hospital, such as taking patients and residents to concerts or football matches.
- Staff wore name badges. However, there was no information on display about the significance of different uniforms to help patients and relatives understand the different staff roles.
- Staff told us they could arrange interpreters when patients and families did not speak English.

Access and flow

- Managers said the hospital had focussed on improving quality, especially in relation to waiting lists and managing delayed patient or resident discharges.
- The hospital did not admit or discharge patients at weekends.
- There was a waiting list for all services at RHN. The hospital kept in touch with referrers to keep them up to date with progress.
- The hospital did not offer any outreach therapy or wheelchair support once patients left RHN.

Brain injury service

- The hospital prioritised patient referrals by date of referral, medical stability and readiness for admission at the time a bed became available, single sex compliance and approved funding. The hospital's Commissioning for Quality and Innovation (CQUIN) goal was 116 admissions for the year, which RHN managers expected to exceed. They were on target for the agreed 119 discharges.
- Staff from RHN assessed about 60% of patients face to face in advance of admission.

Good

Long term conditions

- At the time of the inspection in March 2017, 10 patients were on the active waiting list and 14 patients on a suspended waiting list because they were clinically unwell or waiting intervention.
- The average waiting time for admission to the brain injury service was 69 days. The service was no longer an outlier for waiting times as it had been at the time of the previous inspection which was an improvement. The time from the onset of a patient's condition to admission depended on many factors, including whether they were awaiting procedures at an acute hospital. The average length of stay in the unit was 120 days. Length of stay varied depending on whether patients had a prolonged disorder of consciousness (PDOC) or were having rehabilitation. The average length of stay for patients with PDOC was 98 days.
- On Drapers Ward, the hospital admitted patients for more active rehabilitation for a minimum of 12 weeks. Staff would make a case for longer stays when further rehabilitation therapy was likely to lead to significant improvement. Some patients on Drapers Ward at the time of the inspection had completed their therapy and were awaiting a suitable placement.
- Managers told us staff planned discharge in collaboration with families and clinical commissioning groups. Some families told us they felt staff did not support them enough in planning for discharge. Managers told us the hospital was looking at how to improve families' involvement.
- Wheelchairs were on loan and funded by local clinical commissioning groups (CCGs) or social services. This meant patients moving to nursing homes outside the area could encounter problems because RHN owned their wheelchairs which were only on loan. In such cases RHN were sometimes able to make a temporary loan.

Specialist services and nursing home

- The admissions office checked details of referred patients and a consultant or GP then assessed the referral. A patient deemed to fit the RHN criteria was added to a waiting list until funding was agreed. The hospital provided an estimated waiting time for admission to referrers.
- At the time of our inspection in March 2017, two residents were awaiting a place in the Specialist Nursing Home, and three were waiting for a place on the ventilator unit.
- 90% of nursing home patients came from the brain injury service. On very rare occasions patients could return to the brain injury for further therapy.
- Many patients spend their lives at RHN. One resident had been there since 1976 (49 years).

Meeting people's individual needs

- Managers told us every potential patient or resident and their family was encouraged to attend a pre-admission visit to the hospital to see the facilities, meet the team and understand the care available. A welcome pack supplemented this.
- A lifestyle questionnaire sent to families to identify the person's likes and dislikes in terms of activities. This was captured in an "All about me" booklet to help staff respond to peoples' holistic needs by understanding their preferences, now or before their injury.
- People's gender, race, religion and nationality were recorded in notes and the provider had policies about equal treatment although the provider did not have processes to monitor equality of treatment of patients.
- To meet patients' and residents' medical needs without the need to travel to an acute hospital a wide range of clinics were run on site. These included a splint clinic (three times a week), a tracheostomy clinic, a swallowing clinic and a monthly ENT clinic. There was a postural management service for wheelchairs and bed positioning.
- We found that permanent staff were knowledgeable about the patients' and residents' health. However, we observed that some agency staff did not always read the information about patients before giving care.
- The leisure service organised a programme of events and activities to support the wider wellbeing needs of patients and residents. Most of these events were free and some were also open to family, carers and friends. These include live music events and music groups, arts-based workshops, gardening, literature (including a comprehensive audio library and one-to-one reading), pool activities, adapted sports (including Boccia), a range of trips (including theatre, shops and football matches), and events around national festivities. During our inspection we saw films and music provided in one of the lounges and evidence of patients and relatives were enjoying themselves.

- Some families decorated their loved one's room to reflect their interests, for example a football supporter's room had pictures and posters.
- Volunteers rather than healthcare assistants generally took patients to activities in the hospital. Nurses often provided support to residents on visits outside the hospital.
- Supporting patients and residents to communicate was a specialty of the hospital and we saw excellent use of technology to support communication. The communication service supported all patients and trialled bespoke devices, such as a call button for someone paralysed from neck down and protective covering on a device for a patient in the challenging behaviour unit. However a number of staff did not have regular training on how to support patients to communicate in day to day care situations.
- Visiting hours were controlled. Information on visiting hours was available on each ward. Staff explained limiting the visiting hours gave time for patients to complete their treatments or therapies and have rest periods. On the BIS, patients required dedicated periods of rest to maximise the potential for recovery, so open visiting was not appropriate for these patients. There were no set visiting hours in the long term nursing home.
- To make visiting easier for relatives who lived outside of the area, a limited number of short-stay affordable rooms were available within the grounds.
- Managers told us there were the agreed numbers of staff on duty every day, the perception of some residents and their families was that there were not enough staff to meet patient's needs, for example for showering and hair-washing.
- The Board had approved a strategy to improve the quality and choice of food. This had been a concern at the previous inspection. Patients and relatives told us there was greater choice including culturally specific meals and most meals could be prepared in different textures: normal, fork mash, pre-mash or thick puree for those with swallowing difficulties.
- People had access to specialist cutlery, plates and beakers to assist them in eating and drinking independently.
- A system of patient representatives on each ward provided a means of communication between patients and their families, and the board and executive. Notes of meetings were on display in the hospital so families could see the results of action taken.
- Support for relatives was available from social workers. There was a benefits and welfare administration service. There were free legal advice seminars. The hospital also supported social events such as ward parties and coffee mornings. The recently published strategy proposed a more comprehensive family support service (with the involvement of families), initially focusing on improving information, practical and emotional, and on staff training & support.
- Intravenous (IV) antibiotic administration was under consideration for otherwise stable patients to prevent the distress for patients and families when patients or residents with complex needs had to be transferred to an acute hospital. This would save time and resources in appropriate cases.

Brain injury service

- On Drapers Ward, a named nurse system had been introduced recently to improve continuity of care. Up to date weekly activity timetables for patients were on display as well as information about medical conditions, the mental health act and controlled drugs.
- RHN provided transport for patients in the Brain Injury Service, Ventilator unit or neuro-behavioural service to take them to external medical appointments.
- Some patients used the hydrotherapy pool to achieve goals such as decreasing tone and increasing the range of movement.
- On Devonshire Ward, we observed music therapy personalised to patients and noted signs of responsiveness in patients who otherwise had low awareness. Relaxation therapy was also available for patients.
- An area of concern relatives mentioned to us was that if patients were admitted to an acute hospital they risked losing their place at RHN. This practice followed the NHS England protocol but caused stress for families. Such patients were given priority for readmission when stable.

Good

Long term conditions

Specialist services

- Since our last inspection, the hospital had monitored noise levels in the ventilator unit. This led to the alarm volumes being reduced which improved patient satisfaction and the working environment for staff.

Nursing home

- Since the previous inspection, we found evidence of improved access to in-house health services, dentistry and alternative therapy services for wheelchair-reliant residents. The range of leisure activities had increased and the leisure team were present at weekends and bank holidays.
- The volunteer workforce had expanded through a partnership with the medical school at Imperial College, London.
- Staff told us they were also seeking to achieve a better continuum of care for patients transferring from rehabilitation to the nursing home. Relatives told us about an abrupt change in therapy levels when someone transferred to the nursing home from the BIS.

Concerns and complaints

- The complaints policy was due for review in February 2017, so the review was slightly overdue. The policy followed the three stage procedure of the Association of Independent Healthcare Organisations. Managers discussed complaints weekly at the Executive management team meeting.
- Records showed the number of complaints had declined over a three year period. Between October 2015 and September 2016 there were 119 complaints, of which 20 were formal complaints. Staff analysed both formal and informal complaints. None of the formal complaints were referred to the Ombudsman. There were also 33 compliments in that period.
- Following the inspection the provider told us that the results from the 2017 patient and relative survey showed that 92% of respondents reported that their complaint was partly or fully resolved to their satisfaction. This was a significant increase from the previous year's result,
- Patients, residents and families knew how to make a complaint. We saw leaflets entitled 'Tell us your views' around the hospital as well as accessible information for patients and relatives on how to make comments, compliments, suggestions or complaints. Families were informed how to progress their complaint to an external body if they were not happy with the hospital's internal process.
- The main themes of complaints were nursing care (45%), communication (20%) and medical care (15%). We spoke with a number of families about complaints and found a variety of views. Some said concerns had been resolved appropriately but others told us managers were less responsive. Relatives were frustrated that the same concerns arose repeatedly because the issues were never fully resolved
- We reviewed three complaint records in detail and considered the internal process lacked structure. There was no formal documentation agreeing the terms of reference with the complainant before the start of an investigation, and we did not see evidence of documented assurance that the outcome of the investigation made a difference to the complainant. This corroborated what some relatives told us. They were frustrated that complaints had not led to change, and said the process was slow, and that some complaints could have been settled through meetings rather than in correspondence.
- We saw some evidence of lessons learned from a complaint about respiratory care and communication. The hospital now employed a respiratory nurse and had increased staff training on communicating with patients.

Brain injury service

- Complaints about the brain injury service had reduced by 60% since 2014-2015. Staff told us the service used to get complaints about access but an improved pre-admissions process, including better management of expectations, had reduced this.

Are long term conditions well-led?

Good

We rated well-led as good.

Leadership within the service

- The chief executive led the hospital and was visible on a daily basis visiting wards and speaking with staff and patients. Seven executive directors each had a clear portfolio: finance, fundraising and communications, nursing, chief operating officer, medical director,

director of research, and director of governance. The executive management team, all permanent members of staff, reported to the trustees every six weeks. They met weekly informally and formally every month. They reviewed policies on a rolling basis.

- The chief executive told us a senior leadership programme had helped build senior staff relationships, and had led to excellent results.
- The chairman, CEO, other trustees and executives made themselves visible to patients, relatives and staff by visiting wards visited wards and departments. They sought to listen to staff, patients and families and to identify small things that could make a big difference. They reported their feedback to the executive, committees and board as appropriate. Staff reported good engagement with the trustees. Many staff, including night staff, knew the senior staff and some trustees.
- Nurses and therapists told us they felt the consistency in senior leadership over the past year was helpful. Family members told us the new chief executive showed 'exceptional' leadership, and was visible to everyone.

Vision and strategy

- RHN had a published strategy "Our plan for the future 2016-2020" which had been developed through engagement with staff. The vision was for people with severe disability due to neurological impairment to enjoy the highest possible quality of life. We saw the service values on display: seeing the whole person, willingness to learn, delivery on promises and honesty and integrity. There were plans to grow the services, develop clinical leadership, invest as well as raise funds, and continue to carry out research and education. Staff we spoke with understood the vision and a number of staff clearly modelled the values in their behaviours.
- The hospital had developed a Care Charter which aimed to: explain what patients and residents could expect from the hospital and what the hospital asked of them; encourage patients and families to tell RHN if they were not meeting standards; encourage the hospital to think about how they can make a difference; and ensure the hospital is a place patients and residents would recommend to their friends and families.
- The specific aims for the brain injury service included participating in and influencing the London-wide review of specialist level 1 rehabilitation services; demonstrating the effectiveness of the hospital's PDOC service, optimising the ward environment for rehabilitation.

Governance, risk management and quality measurement

- RHN was founded as a charity to help those whom others found it difficult to help, due to the complexity of their brain injuries. The charity was managed by a board of thirteen non-executive trustees. The board included doctors, a nurse representative, and the perspective of a family member of a resident or patient. The chairman saw his primary role as to implement the articles of charity and have financial responsibility and oversight. An important part of his role was to ensure the hospital met the original charitable intent of the organisation.
- The board set the strategy and held the executive to account. It met quarterly and was supported by trustee-chaired committees through which executive committees reported. The first half of each board meeting focused on people issues. The governance framework gave the board assurance about the quality and safety of services. This was achieved formally through the risk register, the quarterly patient safety and quality report (which was organised under CQC key lines of enquiry), the minutes of committee meetings and reports, as well as informally through unannounced visits to the wards.
- The top risks on the risk register were medicine management, management of deteriorating patients, diabetes management and the pension fund deficit. There were plans in place to mitigate these risks. It remained challenging to recruit and retain enough qualified nurses, but the use of a preferred nursing agency with a specific staff training requirement, and the establishment of a "bank" within the past year, was helping improve staff numbers and skills.
- The hospital's clinical governance framework set our staff reporting lines and held professionals responsible for decision making at different levels. The clinical governance plan for the year included an audit programme, measurements of effectiveness, risk management, and a learning and development and service plan.
- The hospital carried out a number of audits each year. Some of the audits did not reveal expected level of good practice, and where this occurred, re-audit was planned

after further staff training on expected standards. The services had a business meeting every two weeks to review governance issues such as incidents and audit results.
- The clinical risk manager oversaw changes in NICE guidance and patient safety alerts from the Central Alerting System and disseminated information to staff.
- The Board Medical Committee, led by the medical director comprised medically qualified trustees, RHN consultants, the Chief Executive, the Director of Operations, the director of Governance and the Chief Nurse. It met five times a year and oversaw the medical structure and discussed ideas with the board and executive. The medical assurance process was through the Patient Safety & Quality committee (PS&QC) which reported to the Management Board and to every quarterly board meeting. The Medical Committee reported relevant issues, for example on morbidity, to the Clinical Risk and Incident Committee.

Culture within the service

- Medical staff, managers and therapists were very positive about improvements in the hospital culture over the previous year. They reported that managers had involved staff more than in the past. For example, all staff had been invited to meetings help shape the new strategy through a series of events and meetings.
- As well as a leadership programme involving staff of different levels, there was a programme with nurses, HCAs and ward administrators to help identify staff skills and talents. There were workshops on humanisation which were about treating everyone as an individual with their own physical, mental and emotional needs. This had the potential to benefit staff as well as patients, by asking for their opinion, giving choice, and treating them with dignity and respect.
- The hospital had introduced Schwartz rounds to provide a structured forum for staff to discuss the emotional and social aspects of working in the hospital. These had the potential to reduce hierarchies. Some staff told us they found them 'useful' and that they 'liked them', although some said the timing was not convenient for everyone. Schwartz rounds were also held for night staff. Following the inspection the provider told us they had experimented with different timings for the Schwartz rounds.
- Although we saw that managers had worked on bringing staff together, not all staff worked across the whole hospital which meant patients moving from the Brain injury service to the specialist nursing home did have continuity of care. We also observed that nurses and HCAs did always seem to work together as a team on wards
- AAC staff, who were employed by the RHN to provide communications technology said they had little input into hospital activity except in relation to specialist technology.
- The target for sickness absence was 4%. Nurse sickness levels were higher at 6% but the average was 3.8% (2016). Turnover rates were above the target of 20%, at 21.5% overall.

- The leadership demonstrated awareness of the Workforce Race Equality Standard (WRES), which was part of the NHS contract. 48% of staff were from a black or ethnic minority background. However, there was a lack of direction regarding development and organisational commitment. Although the workforce data indicators of the WRES had been analysed and showed a mixed picture in scores between white and BME staff, steps had yet been taken to draw up and implement an action plan ensure all staff were treated equally and supported to fulfil their full potential. The hospital subsequently told us that they were on track for publication on their website of four of the nine standards in October 2017. They had revised their staff survey to ask additional questions and intended to meet the final five standards by January 2018.
- The Staff survey explored indicators of workforce equality as part of the hospitals quarterly 'pulse survey'. However, staff were not asked to disclose their ethnicity
- Governance and policies lacked clarity and evidence of how WRES was represented in the organisation. The executive management team approved a Diversity, Equality and Inclusion Plan in February 2017 but this had not involved staff widely.

Public and staff engagement

- Management sought feedback from relatives, patients and residents through an annual questionnaire.
- A Patients Representative Committee (PRC) met bi-monthly, chaired by a Board member who reported quarterly to the Board. The meetings provided an opportunity to update families on developments and take up any issues families identified. There was a representative from each ward, either a patient, a relative or a volunteer. Ward representatives'

photographs, names and details were advertised on each ward, as were the minutes and results of actions which provided a means of communication between managers, patients and relatives. A large number of managers attended: heads of service, staff from Leisure and Family Services, Patient Safety and Quality and directors.

- The hospital undertook an annual survey of patients and families to seek their views on a range of topics
- At the previous inspection, we had considered there was room for improvement in listening to patients, relatives and staff concerns. We saw some evidence of improvement. However, we considered there was still room for staff to show greater flexibility in making adjustments to support individual family's requests for the way they would like to support their relative. Families who noticed the impact of medicine changes, for example, felt doctors did not take account of their views even though they knew the patient better than staff. We observed some defensiveness from staff in response to some relatives' suggestions about how the hospital could provide a more personalised response to their wishes in relation to their family member.
- We noted relatives supported each other. We saw one ward manager utilised this relationship to guide a family through the grieving process which helped them come to terms with the reality and prognosis of their relative's illness.
- The annual staff survey showed that staff morale level increased from 66.25% in December 2015 to 81.55% in September 2016. The level of job satisfaction had risen to 84% from 68% in 2014, and the sense that staff felt valued and recognised had risen to 72% (51% in 2014). Staff could nominate colleagues for staff awards.
- Most permanent staff we spoke with felt supported by their colleagues and felt able to speak to managers and air their views.
- We saw the whistleblowing policy advertised. Staff told us if they encountered unsafe or poor practice they had access to a whistleblowing procedure. Those we spoke with knew how to escalate concerns and were aware of who they could talk to.
- Most staff interviewed by CQC in focus groups spoke positively about the working environment and culture, although a small number of healthcare assistants felt nurses and senior management support did not support them in managing complaints from relatives.
- 91% of staff recommended the Royal Hospital as a provider of care.
- We noted that some of the staff office accommodation in the basement, where Human Resources (HR) and Information Technology (IT) staff worked were in need of refurbishment.

Innovation, Improvement and Sustainability

- The hospital's Institute of Neuro-palliative Rehabilitation (INR) researched clinical advances, provided factual information for families, professionals and policy-makers, and for the past four years had hosted two national conferences a year. The conferences for 2017 were on 'end of life in disorders of consciousness' and 'craniectomies in severe brain injuries'. The conferences attracted a national and sometimes international audience.
- Staff told us the conferences and other specialist courses, lectures, seminars, conferences and career days for medical professionals and volunteers were an opportunity to strengthen networks with clinicians, academics and researchers.
- A Research and Innovation Opportunities team met monthly to consider clinical developments and their research potential in relation to patients at the hospital. They had carried out research on sleeping patterns (circadian rhythms), music and light, near- infra-red spectroscopy, garden therapy for neuro-disability, carer fatigue and the development, piloting, validity and reliability testing of PDOC outcome measures. The research team had supported the ventilator unit in assessing the loudness of alarms and the disruption this caused to patients.
- RHN had developed a one year programme designed to equip registered nurses with the competencies, knowledge and skills to promote excellence in rehabilitation nursing through evidence based best practise. The training was currently accredited through the Royal College of Nursing.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital was using a range of high technology bespoke communication devices for example eye gaze software (using the direction of a person's gaze to detect the point on which a person's eyes are focused) or specialist switches operated by heads, arms or feet to enable patients to communicate their needs and wishes.
- We also saw the effective use of therapy through technology e.g. specialist speech and language therapy software, soft and hardware, specialist movement software such as biometric equipment and adapted gaming equipment.
- The chaplaincy service provided outstanding emotional support to patients, residents, families and staff.

Areas for improvement

Action the provider MUST take to improve

- Ensure ward staff have more training both on the different degrees of decision-making ability among patients and residents, and the types of decisions each is able to make, and also on the risks to patients and residents of not following the guidance for eating and drinking.
- Ensure all staff have an annual appraisal
- Improve standards of hand hygiene.
- Ensure that all residents in the specialist nursing home have all aspects of their care plans reviewed at intervals in line with national practice.
- Adopt a more structured process for handling complaints, working with the complainant as a far as possible to ensure both sides were satisfied with the outcome.
- Ensure that patients' fluid balances are monitored systematically by adding up fluid balances on charts.

Action the provider SHOULD take to improve

- Ensure staff are encouraged to record patient notes contemporaneously, and have time to do this.

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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Not all staff received appropriate support, training, professional development and appraisal to carry out their duties** • Some staff did not have an up to date annual appraisal. • Some staff supporting people who had swallowing difficulties did not have sufficient training to provided safe care. • Some staff were not trained on how to help patients and residents make choices within the range of which they were capable, which constituted some infringement of their rights. Regulation 18 (2) (a)