Frenchay Brain Injury Rehabilitation Centre

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Frenchay Brain Injury Rehabilitation Centre is operated by Huntercombe Properties (Frenchay) Limited. The hospital has 52 beds. Facilities comprise of a purpose-built building with full therapy suite including a hydrotherapy pool and transitional accommodation.

The hospital provides medical care for patients with moderate to severe cognitive and behavioural disability following acquired brain injury.

We inspected this service using our focused inspection methodology due to concerns identified. We carried out an unannounced inspection on 9 and 10 October 2018 and looked specifically at the safe and well led domains.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this hospital stayed the same. We were unable to give an overall rating to the service as we only looked at the safe and well led domains. However, we found:

- Equipment was not stored securely or checked in line with hospital policy.
- Patient records were not stored securely.
- Substances hazardous to health were not stored securely.
- National early warning scores were not always calculated or acted on and these were not formally audited for compliance.
- Learning from audits, incidents and data collection was not shared with staff or used to drive improvement or change to practice.

However,

- There was a positive and collaborative relationship amongst staff. Staff felt supported and confident in raising concerns.
- Staff had a good awareness of safeguarding roles and responsibilities and there were clear safeguarding processes and procedures.
- There was a positive culture within the organisation where patient care was at the forefront.

Following this inspection, we told the provider it must take some actions to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices which affected the medical core service. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Overall summary

Frenchay Brain Injury Rehabilitation Centre is operated by Huntercombe Properties (Frenchay) Limited. It is a private hospital in Bristol and contains 52 beds. The hospital primarily serves the communities of the Bristol, North Somerset and South Gloucestershire. It also accepts patient referrals for level one beds, from the whole of the South West. Level one beds are for patients who need specialist intensive care and therapy from a specialised and multidisciplinary team. Arrangements existed with a local NHS trust to provide medical staff to undertake medical care and treatment.

This service specialises in the assessment, treatment and rehabilitation of patients with complex physical and cognitive impairments, challenging behaviours and neuropsychiatric disorders resulting from a brain injury. The centre can care for patients detained under the Mental Health Act 1983 or on a Deprivation of Liberty Safeguard Order (DoLS). The centre can also care for patients aged 16 years or above, although patients aged 16 to 17 were rarely cared for.

The service treats NHS patients who have a period of care commissioned by their local commissioning body. It can also provide care to privately funded patients. Patients are usually admitted from an acute hospital following medical stabilisation and either discharged home, to permanent community placements or supported living.

The hospital has had a registered manager, Alison Woods, in post since 2001. Frenchay Brain Injury Rehabilitation Centre is registered to provide the following regulated activities: Treatment disease, disorder or injury; Diagnostic and screening procedures and Assessment of medical treatment for persons detained under the Mental Health Act 1983.

Frenchay Brain Injury Rehabilitation Centre has been inspected three times since their registration. The most recent inspection was in February 2016 where the service met all CQC national standards it was assessed against. It was previously inspected under CQC mental health methodology and was issued no requirement notices and three service improvement recommendations. This inspection was carried out under CQC acute hospitals methodology. Additionally, because we only inspected against the safe and well led domains, we cannot aggregate ratings against previous inspections. This means we cannot provide an overall location rating from this responsive, focussed inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Not sufficient evidence to rate 	Medical care services were the main hospital activity. We rated this service as requires improvement in the safe and well led domains. We did not inspect the effective, caring or responsive domains.

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Background to Frenchay Brain Injury Rehabilitation Centre

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Our inspection team

The team that inspected the service comprised of a CQC inspection manager, one CQC lead inspector, and one other CQC inspector. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection for the South West region.

Information about Frenchay Brain Injury Rehabilitation Centre

The hospital has two wards and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Assessment of medical treatment for persons detained under the Mental Health Act 1983

During the inspection, we visited both the North and South building. We spoke with 38 staff including; nurses, rehabilitation assistants, medical staff,

Summary of this inspection

neuropsychologists, therapy staff, the medical director, the head of therapies and the interim head of nursing. We spoke with five patients and two relatives. During our inspection, we reviewed seven sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected three times before, and the most recent inspection took place in February 2016, which found the hospital was meeting all standards of quality and safety it was inspected against.

Activity

- In the reporting period October 2017 to October 2018 99% of care given was NHS funded activity with the remaining 1% of care being privately funded.
- The hospital employed four consultants, 95 nurses, 10 physiotherapists, nine occupational therapists, nine speech and language therapists, three psychologists and two psychology assistants, (since our inspection a further psychologist has been employed), one dietician, three therapy assistants and 27 non- clinical staff. There were also three doctors employed by a local NHS trust who worked in the service.

Track record on safety between April 2018 and September 2018:

- No Never events
- 544 clinical incidents, of which 388 were no harm, 53 minor harm, 26 moderate harm, 69 near misses, no serious injury, no death

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.

Services provided at the hospital under service level agreement:

- Pharmacy services
- Hospital at night team support
- Clinical fellow medical staffing

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?

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Equipment and substances were not stored securely. We found substances hazardous to health, sharps and oxygen cylinders unlocked and accessible to patients and visitors.
- Resuscitation equipment was not checked in line with policy.
- No registered nurses were trained in immediate life support.
- Records and other patient confidential information was not secure. We found unlocked and patient records in unattended areas.
- Patient risk was not always identified. National early warning scores were not all recorded and acted on.
- Staffing levels did not always meet national guidance.
- There was a high reliance on bank and agency staff.
- Some patient identification bands were so worn they did not contain any patient identifiable information.
- Standards of cleanliness were not regularly reviewed and we saw evidence of poor practices to prevent the spread of infection.
- Feedback from incidents was varied. It was not clear if learning from incidents was always embedded throughout the workforce.

However:

- Staff spoke positively about mandatory training and being provided the time or paid for overtime to attend.
- There was a good awareness of safeguarding roles and responsibilities.
- Staff spoke of being supported to raise all incidents including near misses.
- Medicines were ordered, transported, disposed of safely and securely.

Are services effective?

We did not inspect this area of the service, as this was a focused inspection specifically looking at safe and well-led.

Are services caring?

We did not inspect this area of the service, as this was a focused inspection specifically looking at safe and well-led.

Summary of this inspection

Are services responsive?

We did not inspect this area of the service, as this was a focused inspection specifically looking at safe and well-led.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Systems did not keep patient information secure.
- There was no consistent vision for the service and the strategy to achieve the different visions were limited.
- Data was collected, however it was not always used to drive improvement or shared with staff.
- The audit programme did not take local issues into account.
- The risk register did not reflect the risks expressed by staff.

However:

- Staff spoke of a change in culture which supported raising concerns.
- Staff reported leaders were visible and approachable.
- The organisation actively engaged with patients and their relatives to seek their opinions.
- There were collaborative working relationships amongst all staff who were driven to provide good care to patients.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	N/A	N/A	N/A	Requires improvement	Not rated
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	N/A

Notes

Not sufficient evidence to rate

Medical care

Safe	Requires improvement
Effective	
Caring	
Responsive	
Well-led	Requires improvement

Are medical care services safe?

Requires improvement

Our rating of safe went down. We rated it as **requires improvement.**

Mandatory training

- Staff received training in safety systems, processes and practices. The hospital provided a programme of mandatory training and regular updates for staff, which included fire training, information governance, basic life support and manual handling. Data provided by the hospital showed the service achieved 84% or above compliance in all areas apart from Control of Substances Hazardous to Health 81%, General Data Protection Regulation 77%, positive behaviour management and basic life support 70%. The organisation informed us the low compliance rate for basic life support training levels was because of new staff starting who had not yet completed this. Training had been booked which would increase compliance levels to 98%. We were not made aware of an organisational mandatory training target.
- The organisation provided mandatory training on an annual basis to all staff face -to -face and through an electronic platform. Staff felt supported in training. In the most recent staff survey, 92.1% of staff reported they were supported in receiving training, learning or development. Staff we spoke with reported they were given the time to attend training. If they were required to complete training at times outside their normal working time, they were paid for this as it was classed as overtime.
- Responsibility for attending training was held by individual staff and managers. Staff could access their individual training records through an online portal. Senior staff members could access team and individual training levels electronically and we were informed a check of these records was carried out on a monthly basis through a shared responsibility. Managers then contacted individuals through email or conversation when training was required. There was no alert system to inform individuals of their own training need and required staff to find the time to access their own records.
- Staff received information in changes to safety systems, processes and practices. The hospital communicated changes of practice through daily safety huddles and daily briefings. We also saw displays of national patient safety alerts on display boards in the south unit.
- Staff were trained in the management of sepsis of the deteriorating patient. Staff reported they had received training in the national early warning score on induction as part of an electronic learning course.

Safeguarding

- The hospital had clear organisational arrangements for the governance of safeguarding. There was an identified safeguarding lead and process for acting on and reporting safeguarding concerns. When a safeguarding concern was raised this was reviewed by senior staff members to determine if a safeguarding referral to the local authority was required. If this decision was not clear, three senior staff members met to provide advice and reach a decision. If following this meeting it was still not clear, staff contacted the local authority for advice and guidance. Between September 2017 and August

2018, 24 safeguarding referrals were made to the local authority, of which three related to care given by staff. The service took action when concerns were made about staff conduct.

- Information about safeguarding was shared with others. We reviewed notifications we had received from the organisation and found referrals had been made to the local authority. Senior staff understood the importance of sharing information with other organisations. Where incidents related to agency staff members, the organisation shared their concerns with both the local authority and the agency who employed the staff member.
- However, it was unclear how information was communicated about safeguarding concerns within Frenchay Brain Injury Rehabilitation Unit. We were informed an alert could be placed on the computer system to alert staff of those patients had a safeguarding alert. However, we did not see any of these alerts when we reviewed records on this system. One staff member we spoke with was unaware of any safeguarding referrals had been made. We were therefore not assured all staff would be aware of those patients with safeguarding concerns.
- There were systems, processes and practices to keep both adults and children safe from abuse. Staff had good knowledge of their roles and responsibilities in relation to safeguarding. Staff were clearly able to describe the action they would take if they had a safeguarding concern. They were also aware of the safeguarding policy and where it was located. We observed the safeguarding pathway to be displayed on the notice board in the reception area of the South building.
- Not all staff had received updated safeguarding training. Staff were introduced to safeguarding on induction and yearly updates were part of the mandatory training programme. Training records provided by the organisation showed face to face training compliance for safeguarding level one and level two was nursing staff 69.8%, therapy staff 65.7%, maintenance/ housekeeping/catering 56.3% and admin/doctors 47.3%. E-learning training levels were at 87%. There was an action plan to improve these training levels with five training dates booked and future dates booked for new starters. There was a trajectory for 85% compliance by the end of November and 95% by the middle of December.
- Staff had access to designated safeguarding leads to support decisions about safeguarding. At the time of the inspection there were three senior members of staff who had received training and regular updates a level three in line with national guidance Safeguarding Children and Young People: roles and competencies for health care staff intercollegiate document (2014) and Adult Safeguarding: Roles and competencies for Health Care Staff August 2018. These staff members would act as the safeguarding leads for the unit.
- Additional safeguarding training was available to certain staff. This included level four training and training in raising safeguarding concerns, managing good practice and alerter training.
- Staff received training in positive behavioural support (PBS) and positive behavioural management (PBM). Positive behavioural management is a person-centred approach to manage patients displaying behaviours which are challenging through primary prevention, secondary prevention and finally reactive strategies. Positive behavioural support is a person-centred approach that supports staff to develop an understanding of why a person presents with challenging behaviour, and how to develop alternative ways in which to prevent the behaviour occurring by improving the environment, improving communication and teaching the person new skills. There were five staff members who could provide PBM training to other staff members. Staff reported this was a three-day course which was mandatory for all new staff members, with a yearly refresher course. We observed staff members using this approach to de-escalate a situation. At the time of our inspection 74% of therapists, 72% of nursing staff and 40% bank staff had completed the training PBM training.
- At times, staff experienced abuse in the workplace but action had been taken to reduce the risk posed by the challenging behaviours. We heard of incidences where staff members had been assaulted by both patients and relatives. We reviewed an incident report whereby staff members were assaulted by a member of the public. We

found action had been taken in response to these incidents. Staff we spoke to reported following incidences of assault they had been debriefed and were provided with emotional support.

Cleanliness, infection control and hygiene

- There was a lack of systems to monitor cleanliness. There was no audit checklist or audit timeframe for cleaning supervisors to use to monitor compliance with cleaning standards. The service had not set a cleaning compliance target to measure standards against. We were informed the system was reliant on discussions with individual staff members when poor standards were observed. However, monthly audits which looked at the cleanliness of equipment were undertaken and a twice-yearly audit was undertaken by the infection prevention and control lead. The most recent results showed a compliance of May 75%, June 65%, July 57% and August 85%. We were therefore not assured staff were aware of the processes for minimising cross infection and this information was shared to reduce the risk of cross infection. We were not informed of an organisational audit target.
- Ward and clinical areas were not always cleaned to a high standard. We saw some shower areas to be marked and radiators rusty and dusty. We also observed dirty clothes stored in a disposal bed pan, in the sluice room, on the first morning of our inspection. We found the same clothes to be in the same position and untouched on the second day of our inspection. We also found clean mop heads stored on the floor and a discarded pair of slippers on the floor of the store room.
- Equipment was identified as clean and ready to use. I am clean stickers were used to highlight equipment had been cleaned and thus available and clean to use. These stickers were clearly dated with the date cleaning of the equipment was undertaken.
- Staff had knowledge of infection control processes but did not always follow guidance. We observed staff were bare below the elbows. In the six months prior to the inspection the organisation reported a compliance of between 91-100% for staff being bare below the elbow. However, we saw some staff with painted nails which pose a cross infection risk as well as some staff members with dirt under their finger nails. We also observed some staff members uniforms to be marked. We were informed staff were provided with three sets of uniforms. However, for those staff members who worked for more than three days in a row, this meant they had to try and wash and dry uniforms quickly to be able to wear a clean top each day.
- Hand decontamination audits were completed monthly. We reviewed the audits for the past six months for hand hygiene undertaken before and after patient contact with the following results: May 2018 94%, June 2018 90%, July 2018 93%, August 2018 93%, September 2018 68% and October 2018 95%.
- Hand gel facilities were available on the entrance to the ward areas we visited. However, they were not always clearly signposted to indicate to visitors they were there and should be used on entering the building to help prevent infection.
- There were systems to prevent and protect people from a healthcare-associated infection. Patients were assessed/screened for MRSA on admission regardless of the assessments carried out at previous healthcare organisations they were transferred from. As patients were cared for in single occupancy rooms, the risk of patient cross infection was reduced. We observed signs placed on the doors of patients who were a cross infection risk. These highlighted to staff the need for personal protective equipment to be worn.
- Staff had access to personal protective equipment in different sizes. We observed gloves to be available in all patient rooms we went in. There were a variety of sizes for staff to use and each room was well stocked with these.
- There were low unit infection rates. We observed data for the units and found there had been no reported incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA) or hospital acquired Clostridium difficile (c.diff).
- Staff followed national guidance to minimise the risk of infections associated with urinary catheters. QS61 Statement 4: states, people who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. The use and duration of urinary catheters was audited by the organisation to

monitor compliance with this standard and there was an organisation urinary management guideline. Data provided by the organisation showed 100% compliance with catheter insertion documentation between May to September 2018. It should be noted these audit results are based on a small audit sample as the organisation had a relatively small number of patients with urinary catheters in. Ongoing urinary catheter care was also audited against a catheter care plan. Between May 2018 and September 2018 compliance against the care plan varied from 84% (for three months), 85% and 100%.

- Furniture was mostly clean and in good condition, fully wipe able and compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment 2013. However, we found one chair in the North unit corridor to be worn and in need of repair.

Environment and equipment

- The design, maintenance and use of facilities and premises did not always keep people safe. We found some doors to sluice rooms were unlocked. These rooms contained substances which could be hazardous to patient's health, including toxic and corrosive cleaning agents. We raised this as an area of concern with the organisation on the first day of our inspection. When we returned the next day we found one of the sluice rooms to be locked, however, the sluice room on the top floor of the South building was still unlocked.
- Medical gases were not stored securely. Oxygen cylinders were not stored securely and were left unattended in the South building. We raised this at the time of our inspection, however found these items to still be in the same place and unsecure on the second day of our inspection.
- Sharps and other medical equipment and consumables were not stored securely. We found a cupboard unlocked and unattended on the bottom floor of the south building. This cupboard contained sharps, saline and IV fluids. These were accessible and could be tampered with by unauthorised people such as patients and visitors. We brought this to the attention of leaders on the first day of our inspection, and this was remedied when we returned on day two.
- Staff were trained in the use of equipment. The use of hoists, wheelchairs and emergency evacuation equipment was covered in manual handling training. Training records provided showed training levels were therapists 95%, ward staff 88%, admin/catering/housekeeping 90% and bank staff 72%. Tracheostomy equipment training levels were at 100% apart from nursing staff which was 84%. There were no figures provided for staff training relating to beds, we were informed all staff have a bed demonstration during their supernumerary induction.
- Resuscitation equipment was available but not safely managed. Resuscitation trolleys were available for staff to use; however, they were not stored securely and a lot of the items were not tamper evident. Trolleys on the South unit were stored behind desks, were often unattended and not always within eye sight of staff. During our inspection we found these areas to be isolated from the unit's main activities and rarely populated by staff. These trolleys contained drugs such as adrenaline which were not stored securely and thus accessible to all people on the unit. Although the medicines on the trolley were stored in tamper evident boxes, other items such as saline were not and these were left in areas that were not consistently occupied. One staff member we spoke with was also unaware of where the resuscitation trolley was kept and there were no signs directing staff to it, in the event of an emergency.
- Resuscitation trolleys were not checked in line with the organisations guidance. Guidance written on the wall stated the resuscitation trolleys should be checked daily. We reviewed the records and found they stated checks should be carried out twice a week which was not in line with the guidance displayed. We also found periods where there was no record of checks being carried out for extended periods, for example:
- there was no record of checks being carried out between 4 March to 18 April (top floor of the South building)
- only two checks carried out in the month of January 2018 (top floor of the South building)
- only one check carried out in February 2018 (top floor of the South building)
- The arrangements for managing waste did not always keep people safe. During our inspection we found multiple clinical waste bags stored on the sluice room floor and it was unclear how long they had been kept

there for. Due to the number of bags we were not assured that the three-time daily waste collection had occurred.. However, waste was segregated and waste bags were filled to a safe level. Used sharps were also stored in signed and dated sharp bins were closed to prevent sharp injuries.

- Hospital security did not always keep people safe. We observed external doors to be locked and windows to be on cable like window restrictors to keep patients safe. However, in the previous two years we received two notifications relating to patients who absconded over the garden wall of the unit. At the time of our inspection we found the doors to the garden were unlocked despite a sign displayed on the door stating it should be locked at all times. We raised this with senior staff members and were informed the locking of the doors was carried out based on a risk based approach. If there were patients at risk of absconding then the doors would be actively locked. However, in times where this wasn't the case, the doors would be left unlocked to ensure other patients movements and liberties were not restricted. We were informed of actions that would be taken it a patient was deemed to be at risk of absconding. However, we did not see any of individual risk assessments in patient records we reviewed.
- There was an unpleasant smell associated with the treatment room on the South unit. We raised this with senior staff and were informed this had been investigated and no cause had been identified. However, this odour was strong and was not a nice environment for staff to work in.
- Equipment was mostly maintained and serviced. A central log of equipment was kept and monitored by a senior staff member. We reviewed equipment and found them to be within servicing date. However, we found a kettle and fan in the North building to have no evidence of a recent electrical appliance test. Medical equipment was serviced by a local NHS organisation through a service level agreement. There was a maintenance team on site and employed by Frenchay Brain Injury and Rehabilitation Unit to fix non-medical items.
- Fire equipment was stored securely. We found both foam and carbon dioxide cylinders available for staff to use in the event of a fire. They were stored in a sealed container which was tamper evident. Staff reported fire awareness and management was also part of the mandatory training programme.
- Consumables were in date. We reviewed ten consumables and found them to be stored in sealed packaging and all to be in date.
- Action had been taken following our previous inspection in relation to the de-escalation/quiet rooms. Since our previous inspection a panel had been placed in the door to ensure patient privacy and dignity could be maintained whilst also being able to observe patients where required. This room, although we were informed was not used as a seclusion room, was not able to be locked from the inside. We were informed this room had not been used for seclusion in the past two years.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people. We reviewed records and found assessments of patients were completed on arrival. This included pressure ulcers assessment, venous thromboembolism (VTE) risk assessments and falls risk assessments. A review of those patients at risk and any incidents were discussed at the daily safety huddle.
- Assessments were not regularly updated and not always completed fully. For example, in one record we looked at we found for 44 out of the 50 questions to assess a patient's risk of violence, aggression and suicide were recorded as 'don't know'. We also found a recognised risk assessment for pressure damage assessment had not been reviewed monthly. We reviewed the most recent risk assessment audits results and found variable results. In the four months data was collected out of the five months prior to our inspection, there was 100% compliance with VTE assessments being completed within 24 hours and weekly. However, there was poor compliance with infection prevention control assessments with compliance ranging between 42% and 80% and nutrition assessments with compliance ranging from 58-80%.
- Staff we spoke with had an understanding of sepsis although patient's vital observations were not consistently recorded and acted on correctly. Staff followed national guidance: national early warning score (NEWs) are used to detect and respond to the

clinical deterioration in adult patients. We reviewed eight sets of records and found six out of the eight had not had the observations carried out in line with the guidance and/or scores added up. In one set we looked at the required observations were not carried out six times in a three-day period. We also found scores were not added up correctly or acted on. For example, in one record we reviewed a score of three was recorded at 5:30am which indicates a nurse must be informed. The only action taken in response to this was to retake the patient's temperature at 05:50am where an increase in the previous temperature score was noted. No further action was recorded and observations were not undertaken again until 17:00. This meant we patients at risk of deteriorating may not be identified and action taken. Staff were able to inform us that if a patient had been identified as at risk of sepsis they would be transferred to the local acute hospital and knew how to escalate sepsis concerns. Frenchay Brain Injury and Rehabilitation Unit also stocked antibiotics could be given quickly if sepsis was suspected. However, when speaking to staff they were unsure as to whether the organisation had a sepsis lead and who they were.

- Identification bands were not reviewed regularly. Identification bands are placed on patients to help staff identify the patient and ensure the correct medication and correct treatment is given to the correct patient. We reviewed two patient's identification bands and found one so worn there was no information visible and the other so worn the patients date of birth and hospital number could not be identified. We were therefore not assured staff would be able to confirm a patient's identification prior to treatment or medication being given.
- A limited number of staff were trained in immediate life support. At the time of our inspection, no registered nurses were trained in immediate life support. Although one consultant and three clinical fellows were advanced life support trained, these staff members were only on site between the hours of nine to five. The organisation recognised this as a risk and was on the organisations risk register. However, it had been on the risk register since June 2017. It should be noted that 70% of all staff were trained in basic life support.
- Alert systems were used to highlight patients at risk of falls. We found a gold star to be placed on the door of patients who were at a higher risk of falls. The aim of this was to identify to staff those patients who may need additional support. However, these were not always updated. We found a gold star on one patients door, however, we were then informed this patient was not a high-risk and thus the star should have been removed.
- Care plans were completed and individual to the patient. In the records we reviewed, we found nutritional assessments, fluid charts, oral care plans and stool charts completed. We also found sleep routines charts completed for patients.
- Risk assessments of both patients physical and mental needs were assessed. Patients who were at risk of self-harm were placed in rooms which had been ligature assessed. Ligature risk assessments of both the North and South unit had been undertaken with an environment and ligature risk assessment audit undertaken to assess compliance. Staff were also aware of patients who may pose a risk to them and other patients. In cases like there was an increase in staffing number, for example at the time of our inspection one patient was cared for by two staff members at all times. For these staff members and those caring for patients on a 1:1 basis, they were given an emergency alarm. However, we found a ligature risk in one room of a patient who had been identified at risk of self-harm.
- There was a rapid tranquilisation policy. Rapid tranquilisation is the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. We were informed the use of rapid tranquilisation was used as a last resort and staff tried to use positive behaviour management when possible. For those patients who might require rapid tranquilisation, this was prescribed by doctors as required. Any use of rapid tranquilisation was submitted as an incident and reviewed monthly. However, we were also informed haloperidol was used is some incidences of which there is no reversal agent.
- Staff were able to seek support from senior staff about situations they found difficult. Staff we spoke with reported they could and felt able to seek support and

advice from all staff members. Staff spoke of a cohesive and multidisciplinary approach to assessing patient risk and need. This involved nurse staff, medical staff and therapy staff.

- There was an admissions criteria to ensure only those patients who could be cared for on the units were accepted. Conditions would be accepted as a referral included, traumatic injury, acquired injury and complex strokes. These patients needed to be medically stable with the potential to benefit from rehabilitation and aged 16 and upwards. Patients with additional needs such as stable tracheostomies, PEG tubes and patients with prolonged disorders of consciousness were also accepted.
- There were pathways for referring patients to NHS services if a patient's condition deteriorated. A service level agreement existed for deteriorating patients who required additional medical advice and support. This agreement involved a practitioner who would undertake patient assessments, diagnostic, treatment, referral for speciality advice and referral for Hospital admission.

Nurse staffing

- Vacancies existed in some teams. At the time of our inspection, the therapies teams (physiotherapists, occupational therapists and speech and language therapists) were fully staffed with the speech and language team being over established. However, there was one neuropsychology vacancy which had existed for nearly two years. Although the organisation had attempted to fill this vacancy, this had affected the level of support the employed neuropsychologists could give, with a greater reliance on technicians.
- Increase patient need sometimes resulted in reduced staffing levels for periods of time. For example, sometimes five staff members were required to care for a patient for certain periods of time. These staff members were taken from the normal ward staffing levels and meant for this period the ward was short staffed and the needs of other patients were not met. Patients and relatives, we spoke with reported varying levels of response to call bells, with most reporting response times were worse on weekends.
- Staffing levels were not always planned and reviewed in line with need and national guidance. At the time of our inspection, there was no acuity tool used to assess the levels of staff against the needs of the patients. We raised this with senior staff who reported they gained assurance around staffing each day through walk arounds. However, staffing levels were not alwaysin line with British Society Specialised Neurorehabilitation Service Standards which states for every 20 beds the percentage of staff caring for the patients should be between 45-60% registered nurses depending on the level of bed. During our inspection, registered nurses on the South unit only accounted for around 30% of staff. We reviewed data, and found between 1 July 2018 to 30 September 2018 there were 25 rehabilitation assistant shifts and 12 registered nursing shifts where planned staffing levels did not meet actual levels. When this occurred the organisation, where possible transferred and moved staff with staff often staying late or arriving early to cover.
- There were arrangements for using bank and agency staff. We were informed where possible bank staff would be used. However, in times where agency staff were required, this was undertaken through a provider wide agency organisation and staff provided had the required skills, qualifications and clearances. When an agency registered nurse was required, staff informed us they received a profile before determining if they were suitable for the organisation. We were informed of times where the agency staff provided did not have the skills for the role or did not perform to the standard required. Senior staff reported when this happened the agency staff were sent home and they would not be used again.
- There was a high reliance on bank and agency staff. Data since January 2018 showed the agency usage as a percentage of hours worked was consistently above the 2% budgetedtarget. Agency usage ranged from 4% to 16% in this period. This posed a risk as these staff were less familiar with the patients and the hospitals processes and procedures.
- The impact on safety was not always assessed and monitored when carrying out changes to the service or staffing. Data provided by the trust showed a higher reliance of agency usage at nights and weekends. For example, in September 2018 there was a 47% reliance on agency staff at nights and 26% on weekends. This had ranged from between 10-33% in the two months

prior to this. We raised this with senior staff at the time of our inspection and they were unaware of any trend relating to this. However, following our data request they informed us they were adding it to the risk register.

- The stability of the workforce was poor. At the time of our inspection there was a 27% turnover of nursing staff and 37% for support staff. There was also a high sickness rate which as a percentage of hours was 22% for registered nurses in September 2018 and 24% for rehabilitation assistants. These figures had not been below 14% in both July and August 2018.
- There were arrangements to induct new and agency staff to keep patients safe. When agency staff arrived on the ward they were provided with both a tour of the ward as well as written guidance. Agency staff we spoke with reported they felt this was adequate to prepare them for the role. However, we spoke with a new member of staff who had not undertaken any electronic training before having clinical responsibilities and thus had not undertaken safeguarding training.
- There was a lack of nursing staff competent in managing tissue viability or diabetes. The organisation had previously relied on the support of a local healthcare organisation to provide this care. However, this was no longer being provided and staff were relying on over the phone advice through an informal arrangement. The organisation had tried to address and mitigate the risk posed by this, through additional training for staff and taking patients, where possible, for appointments in the community.

Medical staffing

- Staffing levels compared well with planned levels. At the time of our inspection medical staffing levels matched the planned staffing levels. The medical staff worked at the organisation were a mix of consultants employed by Frenchay Brain Injury and Rehabilitation Unit and junior medical staff who were employed by a local NHS organisation.
- Guidance on staffing levels did not follow national guidance. At the time of our inspection the organisation had 0.6 whole time equivalent (WTE) non-clinical medical director, three WTE consultants, two WTE /clinical fellows and 0.5 speciality doctor for additional support. This was not in line with the minimum staffing provision for specialist's inpatient rehabilitation services BSRM 2010 (2). This guidance states for every 20 beds at level two there should be 1.2-1.5 WTE consultants, 2 training guides or 1.2 WTE trust doctors and for every 20 beds at level one there should be 2-2.5 consultants, 2-3 training guides or 1.5 trust doctors. The organisation was commissioned for 29 level one beds and 23 level two beds and at the time of our inspection 28 level one beds and 20 level two beds were occupied. This meant the organisation would require at least 4.2 WTE consultants, four training guides or just over three WTE junior doctors or 5 WTE training grades. However, we did not see this negatively impact patients and their care.
- Staffing levels were planned and reviewed with action taken in advance to address possible areas of shortage. We were informed one staff member was due to undertake a period of planned leave. In response to this the organisation had recently appointed a locum, and to aid the transition the newly appointed locum member was undertaking a part time role until the staff member went on leave.
- There was a reliance on locum staff. At the time of our inspection, there had been a neuropsychiatrist vacancy for a couple of months. This vacancy was due to be re-advertised. Due to this vacancy the organisation was relying on a locum neuropsychiatrist to fulfil the role. However, to mitigate the risk of unfilled shifts, the locum neuropsychiatrist had been employed on a long-term locum position.. Since our inspection the organisation have informed us they have recruited to this post.
- There was not a responsible consultant available on site at all times when medical patients were being cared for, however arrangements existed to manage this. Consultant cover was provided between the hours of nine to five Monday to Friday with a consultant on call between 17:00 and 21:00 for urgent non-emergency advice and support. Outside of these hours and on weekends staff could also dial 999 or after 9pm and at weekends could contact the hospital at night team at a local hospital for advice or assistance. The on-call consultant would also attend the unit if required.
- Medical patients were not reviewed during a consultant-delivered ward round at least once every 24 hours. We were informed ward rounds were undertaken on half of the patients once a week. However, safety huddles were undertaken daily which consultants attended. We observed a ward round being undertaken

which was attended by all consultants and the junior doctors/clinical fellows. Staff discussed all aspects of patients care, including, medication, therapy need, capacity and ongoing care arrangements such as access to dental services.

- Patients were seen and assessed by a relevant consultant within 12 hours of admission. We reviewed records and found evidence of this assessment being undertaken in the required timeframe.

Records

- The information needed to deliver safe care and treatment was not always available to relevant staff in a timely and accessible way. Agency staff did not have an individual log in to access and record patient electronic notes. This meant they had to log on to the electronic system using an employed members log in. This not only resulted in a delay in them accessing records but also meant the record of patient care given was under a different staff members name than the one carried out the care.
- Patient records and information was not stored securely. We found the records room on the top floor of the south building to be unlocked and not in view of staff. This room contained multiple patient paper records not only stored in unlocked cabinets but also on top of the cabinets. We raised this on the first day of inspection, and found the door to be locked on our second day. However, we also found records to be left unattended on desks in public areas, and computers left unlocked in unlocked rooms. We also found a communication book tied to a desk which contained different patient details as well as requests from the nurses to the doctors. This meant patients private and confidential information was not secure and protected. There was also a risk any member of the public could write in the book and doctors would interpret this as a request from a nurse.
- People's records contained information about their care and plans of care from other healthcare organisations This was in line with National Institute for Care and Health Excellence (NICE) QS15 statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. We saw evidence both in patient records and communication with staff. For example, we observed ongoing discussion and record of arranging for a patient to undergo surgery at a local hospital.
- Audits of records were undertaken to assess compliance. We reviewed the most recent audit which was undertaken in October 2018. The audit sampled 25% of the service and showed 14 areas audited as meeting the standard and four requiring improvement.
- Discharge summaries contained detailed information about the patients care and ongoing care needs. We reviewed a discharge summary and found it contained thorough information about the patients' medical report, impairments and risk, functional abilities and progress made as well as clear recommendations for future care. There was also a detailed and clear list and contact information for care professionals involved in care after discharge. These discharge summaries were given to the patient on the day of discharge or sent within five days of discharge. The organisation reported they were 100% compliant against this service specification set by NHS England. A discharge summary was also sent to the patients GP on the day of discharge.

Medicines

- Medicines were ordered, transported, disposed of safely and securely. The unit used the services of a pharmacist employed by a local NHS organisation. The staff could order medicines form local healthcare organisations and these were locked away in the treatment room. Any medicines requiring disposal were placed in disposal boxes and returned to the pharmacy.
- Medicines were reviewed regularly through a medicines meeting. This was attended by consultants and junior doctors/clinical fellows. We observed this meeting being undertaken with all patients being reviewed. During this review process the patient's medication, medication stop date and the patient's capacity were assessed.
- Medicines were not all stored in fridges with the temperatures monitored. We found two fridges, however only one record of temperatures being checked. We asked staff which fridge these temperature checks related to, however staff were not clear. We were therefore not assured the correct fridge or both fridges

would have their temperatures checked and monitored. Also, we were not assured staff had an awareness of whether medicines were being routinely checked they were stored at the correct temperature.

- The service did not always make sure people received their medicines as intended at the correct time. Although there were four times daily medication rounds, a number of incidents related to missed medication. For example, in August 2018 there were 12 incidences of missed medication and nine missed medications in June 2018. In one of the three medical charts we reviewed we found one patient had not been given the prescribed pain relief twice.
- Identification bands were not reviewed regularly. Identification bands are placed on patients to help staff identify the patient and ensure the correct medication and correct treatment is given to the correct patient. We reviewed two patient's identification bands and found one so worn there was no information visible and the other so worn the patients date of birth and hospital number could not be identified. This posed a risk that patients may be given the incorrect medication or not given the required medication.
- People received specific advice about their medicines. During our inspection we observed staff to explain the aim of the medication to a patient and listen to the patients concerns surrounding the side effects. However, a Patient Report (March 2018) showed, 84.6% of patients understood the medication they were taking and why. It should be noted this was based on only 14 patient's responses.
- Staff had varied awareness about access to medical gases. There was no piped oxygen on the unit and staff relied on portable oxygen cylinders. A stock of these cylinders was stored securely on site with key access required. When we asked staff on the south unit how they would access this stock out of hours and on weekends when the maintenance team were not available, they were unaware of where and if an additional key existed. This meant there was a risk out of hours and on weekends staff would not know how to obtain additional oxygen quickly if the ward supply ran out.
- Allergies were documented in the prescribing document used. We found an area on the front of the drug sheets for staff to highlight and record any drug allergies. We reviewed three medicine charts and found a record of patient's allergies recorded in all three.
- Dose and duration of treatment of medicines were clearly documented. This was in line with NICE QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record. We reviewed two antibiotic records and found a start and stop date clearly recorded. Boxes were crossed out to indicate the beginning and end of the course.

Incidents

- The hospital managed patient safety incidents. Between September 2017 and September 2018, the hospital reported no never events. A never event is a serious incident is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- The organisation understood their responsibility regarding reporting incidents both internally and externally. Between April 2018 and September 2018, the organisation reported 544 internal incidents. Of these 544, none were reported as serious injury, 26 as moderate harm, 53 as minor harm, 388 as no harm and 79 near miss. The monthly incidents were reported and a break of down of themes was displayed in the entrance area of the South building.
- Staff were aware of their responsibilities regarding reporting incidents. Staff understood the importance of reporting both incidents and near misses and were l aware of the incident reporting process. Staff reported they felt confident in using the incident reporting system and senior staff supported them in raising them. However, the rehabilitation assistants were unable to report incidents on the incident reporting system and required a nurse to assist them. This led to a delay in incidents being reported.
- Incidents were investigated. We reviewed investigations in to serious incidents reported to CQC. Each incident

had been investigated with interviews of staff and a review of documentation to help determine the cause of the incident. However, it was not clear from all the incident reports all root causes had been identified and thus all learning had been identified. For example, one incident related to missed medication. The initial investigation report did not identify the reason behind staff members not being able to find the medication and whether the organisation of the stock cupboard was a contributing factor. Thus, this was not initially identified as a possible change to practice.

- There was learning from both serious and other incidents and change to practice, although it was not clear if this learning was always embedded. Staff spoke about incidents being discussed at safety huddles and daily briefings, however the learning from these incidents was not always clear. For example, we had previously received a notification about a patient who had not been enterally fed, with one of the identified contributing factors was a lack of stock. During our inspection we were made aware a lack of enteral food stock had not been identified until the morning when it was required to give to patients. We were therefore not assured learning had occurred and changes to practice had been embedded.
- Staff did not always receive feedback following the reporting of an incident. The incident reporting system did not have an automatic feedback system. This meant staff were not always provided with feedback and thus the learning and action had been identified following an incident being raised.
- Staff had differing awareness of duty of candour. Duty of candour is a duty whereby, as soon as reasonably practicable after becoming aware a notifiable safety incident has occurred a health service body must notify the relevant person the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Some staff we spoke with had a good understanding of what duty of candour was and meant. However, two other staff were unaware of the terminology, however were able to explain they would be open and honest with patients or relatives if an incident occurred.
- We reviewed four investigation reports and found duty of candour had been applied. Senior staff we spoke with reported the incident reporting system alerted them to duty of candour. Before an incident report could be submitted senior staff had to confirm if duty of candour had been applied, and if not the reason for this decision.

Safety Thermometer (or equivalent)

- The safety performance of the organisation over time was variable. We reviewed safety thermometer results since January 2017 and found performance in all areas varied with no overall trend.
- The organisation compared well with other organisations. When compared to the national average, since January 2017 the organisation had:
- Two episodes where it performed worse than the national pressure ulcer average
- Three episodes where it performed worse than the national average for harm free care
- Four episodes where it performed worse than the national average for patients with a new VTE

However, it should be noted between June 2017 and December 2017 there were no results submitted. We raised this with the organisation and were informed this was due to issues accessing and submitting the report on to the reporting system.

- Safety thermometers were displayed in local areas but were not clear as to the individual areas of performance. At the time of our inspection in October, we observed the safety thermometer result for August 2018 to be displayed with a result of 98%. However, it was not clear to members of the public or patients what this meant, and the individual results for new VTE, new pressure ulcers and so on were not displayed.

Are medical care services effective?

We did not inspect this area of the service, as this was a focused inspection specifically looking at safe and well-led.

Are medical care services caring?

We did not inspect this area of the service, as this was a focused inspection specifically looking at safe and well-led.

Not sufficient evidence to rate

Medical care

Are medical care services responsive?

We did not inspect this area of the service, as this was a focused inspection specifically looking at safe and well-led.

Are medical care services well-led?

Requires improvement

Our rating of well-led went down. We rated it as **requires improvement.**

Leadership

- Leaders had the skills, knowledge, experience and integrity to manage medical services. Leaders of varying levels we spoke with, spoke of a desire to ensure patients received a high standard of care. They had a good awareness of some of the issues they faced in achieving this.
- Leaders understood challenges to quality and sustainability, however actions were not always taken to address these. Leaders we spoke with were aware of the impact and challenge of being the only level one rehabilitation service in the South West and the impact this had on the medical needs of the patients they cared for. They were also aware of the issues with recruitment of both nursing staff and other clinical staff. However, we were not assured action was always taken to minimise these challenges. For example, the reliance on agency staff had been an issue for a sustained period of time. Although recruitment was ongoing, action had not been taken to reduce the reliance on agency staff at weekend and on nights by sharing the employed workforce across these times.
- Leaders were visible and approachable. Staff knew who their senior managers were. In the most recent staff survey from March 2018, 94.1% of staff reported they knew who their senior managers were. This was better than the average NHS percentage of 85.1%. Staff we spoke with reported they often saw the interim nurse manager on the wards and assisting with ward based activities when staffing levels were low.
- Staff felt supported by leaders. Staff we spoke with reported there had been a culture change recently in the organisation. There was an open-door policy and staff felt confident in raising concerns with any member of the leadership team. They felt they would be listened to and action taken where possible. However, staff were not always clear about their roles and who they reported to. We spoke with staff of varying levels of the organisation and some were unaware of who their line manager was. We spoke to a number of rehabilitation assistants who reported they had not received regular performance reviews and were unaware who's role this was.
- There was a leadership development programme. The provider had recently introduced a nursing leadership course. This was supported by the Royal College of Nursing (RCN). The aim of the course was to develop nursing leadership skills and the course involved presentations and residential training.

Vision and strategy

- The service had a vision but not all senior staff were aware of it and these were not always aligned with their own visions for the service. There was a provider wide set of values with quality and patient care as the top priority and an organisation vision. We were informed staff were informed of the vision at corporate induction. However, leaders we spoke with all spoke of different visions for the service which were aligned with their own leadership area. It was hoped following the recent introduction of a therapies lead and employment of a new interim nurse manager, a clear vision would be formed.
- Leaders visions were not all achievable due to limitations in their ability to achieve them. There were visions to improve patient access to the service and make pathways for patients more responsive to patient need. However, the service was limited in its ability to achieve this by the current healthcare environment. The service was the only organisation in the South West commissioned to provide level one care. There was a growing waiting list for the specific type of care offered at the hospital, and thus pressure from commissioning bodies to accept these patients, the organisation did not therefore feel it wasin a position to improve patient pathways.
- Leaders had an awareness of the current health and social care economy and the future impact on Frenchay

Brain Injury and Rehabilitation Unit. The organisation had recently undertaken work for NHS England to help define the characteristics of a good neurobrain rehabilitation healthcare service.

- Action was taken to achieve commissioning for quality and innovation (CQUINS) targets, which is a payment framework encouraging care providers to share and continually improve how care is delivered. Frenchay Brain Injury and Rehabilitation Unit had a CQUIN relating to the referral and discharge of patients from the organisation. They had recently received the results of their performance in this area and were found to be compliant in all but one area. This target related to achieving 98% of patients having an estimated date of discharge planned at their first multidisciplinary meeting; and the local clinical commissioning group informed of this within three working days. This was reviewed and it was found the lack of compliance related to informing the commissioning group within three working days.

Culture

- Staff we spoke with felt supported, respected and valued. They felt there had been a recent shift in the culture of the unit and all reported they would feel confident in raising concerns and obtaining support if needed. We heard of an incident where a staff member was assaulted. Following this incident, the staff member was provided with support, a debrief, time off and a change to their work schedule. However, in the most recent staff survey of March 2018, only 52.5% of staff reported they received support from their managers. This was less than the NHS average of 68.2%.
- Staff development had not been routinely encouraged but action had been taken to address this. In the most recent staff survey only 50% of staff reported they had a conversation around development in the last 12 months. This was a lot less than the NHS average of 86.9%. However, action had been taken to promote development of staff at provider level. The provider had recently introduced a grow your own nurses programme. This was a programme whereby rehabilitation assistants could apply to be accepted on a 12-month funded course to obtain the first part of nursing degree. Following the initial 12 months a further selection process would be undertaken to enable these staff members to undertake the second part of the course which would enable them to obtain a nursing degree. At the time of our inspection this was a newly developed programme and thus we were unable to determine the effectiveness and availability of this to staff. In the previous year, one staff member was given a training position, with ten applicants this year it was hoped the number of positions would increase.
- Patient care was not always perceived as the top priority. Only 62.3% of staff reported felt the care of patients was the organisations top priority in the most recent staff survey. However, staff we spoke with spoke of a recent change in culture.
- The organisation celebrated success and awarded staff. There was a provider wide staff recognition programme called Huntercombe Heroes. Staff, patients and families nominated staff members for these awards. Staff who won would receive a card from the chief executive of the provider as well as a small gift such as a voucher. Long service awards were also given to recognise those staff who had worked for the organisation for an extended period of time.
- There were hospital initiatives supporting the safety and well-being of staff. We were informed the psychology team would provide drop in sessions for staff. These sessions were an opportunity for staff members to discuss situations they may have found difficult. Staff also had access to a provider wide advice line. Staff could be directed and could self-refer to this service for advice and support ranging from finance and physical and emotional wellbeing. There were also a number of hospital groups staff could take an interest in such as a Frenchay Brain Injury and Rehabilitation Unit choir and fitness group.
- There was evidence of team working and cooperative, supportive and appreciative relationships among staff. We observed staff interact with all levels of the organisation. Staff spoke of a collaborative working relationship amongst nursing staff, therapy staff and medical staff. They felt they worked as one team towards the same goal and they all helped each other out.
- Data was collected and submitted to comply with Workforce Race Equality Standards (WRES). All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually

obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. At the time of inspection this data was collected by the organisation and then submitted at a provider level.

- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to provide staff with access to a Speak up Guardian. The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in "Freedom to Speak Up" in 2015. At the time of the inspection there was a provider wide freedom to speak up guardian, however, there was no freedom to speak up lead within Frenchay Brain Injury and Rehabilitation Unit. The staff were made aware of the role and contact information for the freedom to speak up guardian through an email and additional newsletter.

Governance

- There were structures, processes and systems of accountability to support the delivery of services. There was a clear governance structure, which included engagements from all levels. We reviewed minutes of meeting held for the clinical governance team, rehabilitation assistants team meetings and medical team meetings. There was a clear agenda and structure for the minutes of the meeting. Items discussed included risks, incidents reported and quality feedback.
- Information from ward to the governance committee were shared. A standard agenda item of the governance committee meeting was feedback from each area within the organisation, for example occupation therapists, the medical team and physiotherapists. Feedback from provider wide meetings was also discussed as well as any safety alerts.
- Most meeting minutes were informative and clear. However, we found the minutes for the medical team meetings were brief with no evidence of risks or incident being discussed.
- Systems to promote shared learning and information at all levels of the organisation were not always effective. We saw evidence of data being collected and information relating to incidents being discussed, but no evidence of learning being embedded or shared. For example, staff we spoke with were able to discuss incidents had occurred but were not clear on changes to practice had occurred as result. Staff were also unaware of the results of recent audits, for example, hand hygiene, and were therefore not clear if they were compliant or if action was required for improvement.
- There was a systematic programme of clinical and internal audits to monitor quality and operational processes. However, this did not always drive improvement and did not always reflect the areas of need within the organisation. The audit programme was a programme devised by the provider and not the organisation. This meant there were areas required improvement but were not reflected in the audit schedule. For example, the completion of national early warning scores and action taken were not part of the audit programme. This meant staff were unaware of the issues of compliance we found on the inspection. This meant areas required improvement were not always identified and thus change to practice could not take place.
- There was a service level agreement in the event of a deteriorating patient requiring treatment or referral to an NHS organisation. In the event of an emergency the unit would call 999. However, we reviewed the agreement and found it was dated April 2014 with a review required in April 2015. It was not clear whether this review had been undertaken.

Managing risks, issues and performance

- The organisation had systems for identifying risks, however action to reduce or eliminate them was not always carried out in a timely manner. We reviewed the organisations risk register which contained nine risks, two of which had been present since June 2017. Although action to reduce these risks was identified, not all actions had been taken. For example, action taken to reduce a risk of legionella was identified on the 25 June 2018, with the risk being initially placed on the risk register in June 2017. At the most recent review of the risk register on 8 October 2018 it was still awaiting review.
- The risk register did not reflect all risks identified by staff. We did not find all of these risks identified by senior staff recorded. For example, staff expressed concern about the risk posed by the vacancies of

neuropsychologists and the impact this had on the responsiveness of the service they were able to provide. This risk was not on the risk register. We also found some areas of risk identified on the inspection were not reflected on the risk register. For example, the high reliance on agency staff at weekends and nights compared to usage on week days.

- There was limited benchmarking against other organisations to drive improvement. Apart from participation in the national UK Rehabilitation Outcomes Collaborative (UKROC) there was little other participation. The organisation reported they compared their audit results with other organisations under their provider, however as these were of a variety of different services it was difficult to compare fairly.
- Local audits were not always undertaken to highlight areas of poor performance or risk and we were not assured all areas risk and poor performance would be identified and action taken to address these areas. For example, there was no formal audit of national early warning scores undertaken, on inspection we found this to be an area of concern.
- Poor performance was managed. Senior staff told us they would initially try to address performance issues through discussions and training if appropriate. If not, they would seek the support of the hospital director and the provider level human resources team who would help implement and support the use of the Huntercombe Group policy.

Managing information

- Arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were not maintained. We saw rooms containing patient records to be unlocked and records and other patient identifiable information left unattended. The availability of information to all staff was limited with agency staff unable to access and record the records of care they provided.
- Information stored electronically was not always secure. We found one computer unlocked and left unattended in an unlocked room on one of the wards. Confidential emails were left clearly on display.
- There was an understanding of performance with information on quality and operations gathered. However, this information was not always used to drive and measure improvements. We saw examples on the inspection where data and information had been gathered but learning had not been identified as shared. For example, at the time of our inspection there had been an increase in the number of times rapid tranquilisation had been used, from five and seven times to 22 times. We asked staff for the reason behind this, but staff were unaware of the results and if there was any reason or learning. We were therefore not assured data collected drove improvement and all learning and change to practice was identified.
- There were not effective arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate and valid. We reviewed the most recent Resuscitation & Medical Devices Audit was undertaken in June 2018. One of the findings was, 'all resuscitation items are checked daily and this is evidenced by the thorough completion of checklists accompany the equipment per policy'. This does not reflect the evidence we observed whilst on inspection. There was conflicting guidance on the frequency of checks, with the checklist stating the equipment needed to be checked twice a week and the laminated guidance stating it should be carried out daily. Also, the most current risk assessment, carried out in July 2018 stated, the crash trolley is maintained /checked daily (normally done on nightshift). This meant there was risk the information being used to highlight areas of improvement were not accurate and areas of concern or poor practice may not be identified.
- Staff knew where to locate policies and contact information if they needed additional help or information.
- There were no robust service performance measures recorded. We reviewed audit results for different aspects of care, including record assessments. However, although audits were undertaken, the audit response contained a narrative rather than an analysis of the data to measure performance accurately. For example, in the most recent records audit, where the audit assessed whether risk assessments were reviewed, the narrative recorded was, "there was improvement following the

last audit but there was a majority of care plans still not reviewed." However, it was not clear what the previous performance was and what the current performance was.

Engagement

- The organisation had collaborative relationships with external partners although these were sometimes restrictive. The organisation had a working relationship with a local NHS organisation with various service level agreements for advice and clinical support. However, there were areas where this working relationship was not formalised. For example, the organisation had struggled to get a service level agreement for tissue viability and diabetic support and were relying on good will for advice and support where needed.
- The organisation engaged with staff to plan and manage services. Staff views were sought through an annual staff survey. Engagement scores had improved since 2016, with a 59% response rate which is in line with average NHS engagement scores.
- Staff were engaged with in a variety of ways. Staff we spoke with reported as well as the staff survey, senior staff members held regular drop in sessions. These were periods of time where staff could visit senior staff members and discuss anything they wanted to discuss.
- Meetings were regularly. We heard of multiple ways in which staff views were gained. This included team meetings, daily briefings and safety huddles.
- The views of patients and their relatives were sought. Regular patient forum meetings and relative meetings were held. The aim of this group was to obtain patients, carers and relatives opinions and provide a platform for concerns to be raised. An independent advocate was also invited to help support and provide advice. Monthly relatives group were also held and attended by a local brain injury charity. A questionnaire had recently been sent to gain relatives opinions on the topics they wanted to discuss. There was a desire to develop these groups with a view to form a young children's group to help support young people whose parents or relatives may have sustained a brain injury.
- Patients were engaged with and drove service development. A patient representative attended the monthly governance meeting where issues such as incidents and incident themes were discussed. The role of the patient representative was to provide feedback from patients and their experiences to drive improvement.

Learning, continuous improvement and innovation

- The organisation embraced continuous learning, improvement. The main vision of the service was the to be the centre of excellence for specialist neuro-rehabilitation in the South West. Senior staff we spoke with all spoke of a desire to improve services.
- Innovative approaches had been introduced to improve patient experience. The organisation had recently devised a social communication toolkit. This was a toolkit to help staff communicate with and treat patients who may have complex communication needs, for example patients unable to read facial expressions. We were informed organisation had presented this toolkit at speech therapy forums and there was a desire to officially publish the toolkit.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The organisation must ensure equipment and substances hazardous to health are stored securely.
- The organisation must improve the monitoring of resuscitation trolleys.
- The organisation must improve staff knowledge and completion of national early warning scores.
- The organisation must store patient records and other confidential information securely.

Action the provider SHOULD take to improve

- The organisation should provide additional training in the recognition of alternative safeguarding concerns.
- The organisation should regularly audit the cleanliness of areas.
- The organisation should monitor staff compliance with cross infection techniques.
- The organisation should increase the number of staff trained in immediate life support.
- The organisation should increase the number of nursing staff trained in tracheostomy equipment.
- The organisation should review and replace patients' identification bands to ensure they contain the required information.
- The organisation should improve waste management procedures.
- The organisation should review risk assessments for completion and reassessment.
- The organisation should complete risk assessments for those patients at risk of absconding.
- The organisation should review the use of intramuscular haloperidol.
- The organisation should review processes to maintain stock levels.
- The organisation should review processes so care given is recorded under the correct staff member.
- The organisation should improve learning from incidents and ensure learning is embedded.
- The organisation should administer patient's medicines at the correct time.
- The organisation should monitor all fridge temperatures where medicines are stored.
- The organisation should promote shared learning with data collected being used to drive improvement.
- The organisation should review audit processes so that they contain a statistical measure of performance.
- The organisation should implement a freedom to speak up guardian lead.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.— 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all is reasonably practicable to mitigate any such risks; d. ensuring the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; e. ensuring the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; The organisation did not prevent access to hazardous materials. We reviewed eight sets of records and found six out of the eight had not had the observations carried out in line with the guidance and/or scores added up for NEWs. Resuscitation was not checked daily against the policy, and was also not checked twice weekly as directed on the checklist.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

All premises and equipment used by the service provider must be—

a. clean,

b. secure

The organisation had a lack of cleaning audits undertaken.

Oxygen cylinders and other medical equipment was left unsecure.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 2. systems or processes must enable the registered person, in particular, to— c. maintains securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; The organisation did not have processes to ensure patient information was kept confidential. Audit results were not used to drive improvement.