

Royal Devon and Exeter NHS Foundation Trust

Mardon Neuro-rehabilitation Centre

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Requires improvement



Medical care

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Royal Devon and Exeter NHS Foundation Trust as part of our programme of comprehensive inspections of all NHS acute trusts. The trust was identified as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

Level 6 is the lowest level of risk which the trust had been rated since March 2014.

The inspection took place on 2 – 6 November 2015 and included Wonford Hospital and Mardon Neuro-Rehabilitation Centre

We rated the trust as good overall and Mardon Neuro-Rehabilitation as requires improvement overall.

- The chief executive had been in post for 18 years at the time of the inspection. It appeared that the Chair and Chief Executive had a supportive relationship and worked well together. The board overall had the experience, capacity and capability to lead effectively.
- The trust culture is strongly focused on quality and safety with patients being the absolute priority. There was tangible evidence of the culture in trust policies and procedures. This was also a consistent theme in the feedback from staff at all levels in the focus groups and drop in sessions held during the inspection.
- There was an incident review group which reports to the Clinical Governance Committee and reviews all incidents that are categorised as amber or red
- The trust had no never events since 2013. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS trusts are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis.
- The trust performed well on infection rates having had no incidents of MRSA blood stream infection since 2011.
- Staffing in wards was reviewed on a regular basis with evidence of skill mix changes and additional posts being created in some areas. Other areas were finding it hard to recruit with some reliance on bank or agency staff.
- The overall trust target for mandatory training was 75% which had been achieved for topics such as safeguarding. There were some topics which were above the target and some slightly under the target.
- Staff reported communication was good in their local teams through use of 'Comm cells'. These took place regularly with discussions including training, complaints incidents and well as feedback of results of audits.
- For the Mardon Neuro-rehabilitation centre there was a lack of strategy for the provision of a responsive service that delivered care as close to home as possible services seven days a week.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure medicines are administered to patients safely in line with policy and take into account their rights.
- Ensure medicines are disposed of and returned to pharmacy in accordance with the trust's policies and standard operating procedures.

In addition the trust should:

- Ensure there are sufficient therapy staff deployed in order for patients to receive consistent care and according to their needs.
- Ensure incidents are investigated and records are available with a robust process for disseminating information to all staff following incidents investigations.
- Ensure discharge planning processes are pro-active and well co-ordinated to reduce delayed transfers out of the centre.

Summary of findings

- Ensure service strategies are clear and communicated effectively and development plans for the service are identified.
- Identify a lead to develop the service and provide management support at operational level.
- Review feedback from patient surveys and develop action plans to improve patient experience.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Requires improvement

Rating



Why have we given this rating?

We have rated The Mardon Neuro-rehabilitation Centre as requires improvement overall. Effective, caring and responsive were rated as good and safe and well led rated as requires improvement. Medicines were not always managed safely and according to best practice guidance to safeguard patients. This included the covert administration of medicines which were disguised in food. There were not always sufficient numbers of therapists such as speech and language therapists to provide care and support to patients to meet their rehabilitation needs. Patients told us they received appropriate support from nursing staff. There was good multi-disciplinary working for the benefit of patients.

Incidents were monitored and staff followed procedures to report incidents and monitor patients' risks. There was inconsistency in the way that investigations and learning from these were cascaded to staff at local level.

The environment was clean and equipment was well maintained. Infection control procedures were followed to protect patients from risk of cross infection. Staff had access to a variety of equipment to enable and support patients' independence. Regular equipment checks were completed and records were maintained to ensure they were safe for use.

Staff had good understanding of action they would take to safeguard patients in vulnerable situations. The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and mental capacity assessments were completed and reviewed. Although this principle was not followed when administering covert medicines.

Patients were assessed and care plans developed to manage risks. There was no tool used to assess deteriorating patients which could lead to inconsistency in their management. Records were stored securely and available to support patients' care

Summary of findings

Staff provided care based on national guidance such as National Institute for Clinical Excellence (NICE) guidelines and British Society of Rehabilitation Medicine guidance.

Staff received induction and other training and there was a formal process in place for staff to follow to meet requirements of the Duty of Candour. Patients received compassionate care that respected their privacy and dignity. Patients and relatives said they felt involved in decision making about their care.

There were effective governance arrangements that looked at incidents and risks. Staff felt supported by their managers and felt they worked for Mardon centre and were not connected to the wider trust.

The trust had confirmed there was a strategy for Mardon. However this was not known at local level and was not embedded within the unit; for the provision of a responsive service that delivered care as close to home as possible seven days a week. There was a lead for the service, staff said they were not visible in the unit to develop the service and provide management support at operational level. They were available by telephone and visited infrequently.

The trust routinely monitored case mix and outcome data for the purpose of benchmarking and quality monitoring annually as part of a national audit.

Mardon Neuro-rehabilitation Centre

Detailed findings

Services we looked at

Mardon Neuro- Rehabilitation Centre

Medical care for rehabilitation

Detailed findings

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Detailed findings from this inspection

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Background to Mardon Neuro-rehabilitation Centre

The Mardon Neuro Rehabilitation Centre is run by the Royal Devon & Exeter NHS Foundation Trust and is part of the medical directorate. The Centre has 12 beds and cares for sub-acute patients with a variety of neurological conditions. It provides care and services to adult patients in Exeter, and East and Mid Devon and also to patients who may be out of County as far as Cornwall.

There is clearly defined admission criteria to the unit such as patients should have a primary neurological condition, be over 16 years of age and not in full time education. Referrals are received from the acute and community multi-disciplinary team (MDT) teams. GPs contacted the consultant neurologist and all referrals are discussed as part of the weekly MDT meetings.

The Mardon unit has dedicated beds where neurology patients are admitted for assessment and diagnosis of functional symptoms. These patients are admitted for a set period of four weeks for assessments.

There is a specialist multi-disciplinary team approach to assessments and treatment where the team works cohesively to provide a rehabilitation programme. This includes joint working with other agencies in the community with the aim of integrating the patients back into the community. Mardon also provides facilities such as sleep studies for monitoring brain activity as part of assessment of epilepsy.

We undertook this inspection of Mardon Neuro Rehabilitation Centre as part of our inspection of Royal Devon and Exeter NHS Foundation Trust. We observed how people were being cared for and reviewed six patients care records. We also spoke with 11 staff including doctors, nursing auxiliaries, domestic, nurses, therapists, psychologists and the maintenance/ driver for the unit.

The report will reflect some of the data from the medical directorate which Mardon is part of.

Our inspection team

Our inspection team was led by:

Chair: Professor Ted Baker, Deputy Chief Inspector.

Head of Hospital Inspections: Mary Cridge, Care quality Commission

The full inspection team included CQC senior managers, analysts, inspectors and specialist advisors such as

doctors, nurses, allied healthcare professionals; 'experts by experience' and senior NHS managers also joined this team. The inspection team for Mardon Neuro rehabilitation unit comprised of two CQC inspectors, and a specialist advisor who is a physiotherapist.

Detailed findings

How we carried out this inspection

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

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

We carried out the announced part of our inspection between 3 – 6 November 2015. During the inspection we visited a range of wards and departments across the trust and spoke with over 300 clinical and non clinical staff and held focus groups to meet with groups of staff and managers. We observed how people were being cared for, talked with carers and family members and reviewed patients' records of their care and treatment.

Prior to the inspection we obtained feedback and overviews of the trust performance from the New Devon Clinical Commissioning Group and Monitor (the Foundation trust regulator).

We spoke with HealthWatch Devon who shared with us views they had gathered from the public in the year prior to the inspection. In order to gain feedback from people and patients we held some listening events. One of these events was held at a venue in Exeter city centre and two others were held at Honiton and Tiverton Libraries. A total of 50 people came to share their experience with us and we used what they told us to help inform the inspection. We also received feedback that people provided via the CQC website.

Facts and data about Mardon Neuro-rehabilitation Centre

The Mardon Neuro centre was last inspected in August 2012. We reviewed five essential standards during the inspection and Mardon unit was compliant with the standards we inspected.







Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Medical care

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

Information about the service

The Mardon Neuro Rehabilitation Centre is run by the Royal Devon & Exeter NHS Foundation Trust and is part of the Medical Services Division. The Centre has 12 beds and cares for sub-acute patients with a variety of neurological conditions. It provides care and services to adult patients in Exeter, and East and Mid Devon and also to patients who may be out of County as far as Cornwall.

The Centre does not provide care to patients who are under 16 years. There was a clearly defined admission criteria to the unit such as patients should have a primary neurological condition, be over 16 years of age and not in full time education. Referrals were received from the acute and community multi- disciplinary team (MDT) teams. GPs contacted the consultant neurologist and all referrals were discussed as part of the weekly MDT meetings. Mardon Neuro Rehabilitation Centre is part of the Medical Services Division. The team provides a multi-disciplinary approach to care from nurses, doctors and therapists as part of rehabilitation service.

Summary of findings

We have rated The Mardon Neuro Centre as requiring improvement overall with effective, caring, responsive rated as good, and safe and well led as requires improvement.

Medicines were not always managed safely and according to best practice guidance to safeguard patients. This included administration of covert such as medicines which were disguised in food.

There were not always sufficient numbers of therapists such as speech and language therapists to provide care and support to patients to meet their rehabilitation needs. Patients told us they received appropriate support from nursing staff. There was good multi-disciplinary working for the benefit of patients.

Incidents were monitored and staff followed procedures to report incidents and monitor patients' risks. There was inconsistency in the way that investigations and learning from these were cascaded to staff at local level.

The environment was clean and equipment was well maintained. Infection control procedures were followed to protect patients from risk of cross infection. Staff had access to a variety of equipment to enable and support patients' independence. Regular equipment checks were completed and records were maintained to ensure they were safe for use.

Staff had good understanding of action they would take to safeguard patients in vulnerable situations. The

Medical care

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and mental capacity assessments were completed and reviewed. Although this principle was not followed when administering covert medicines.

Patients were assessed and care plans developed to manage risks. There was no tool used to assess deteriorating patients which could lead to inconsistency in their management. Records were stored securely and available to support patients' care

Staff provided care based on national guidance such as National Institute for Clinical Excellence (NICE) guidelines and British Society of Rehabilitation Medicine guidance.

Staff received induction and other training and there was a formal process in place for staff to follow to meet requirements of the Duty of Candour. Patients received compassionate care that respected their privacy and dignity. Patients and relatives said they felt involved in decision making about their care.

There were effective governance arrangements that looked at incidents and risks. Staff felt supported by their managers and felt they worked for Mardon centre and were not connected to the wider trust.

There was a lack of strategy for the provision of a responsive service that delivered care as close to home as possible seven days a week. Resources were not used effectively and there was no lead to develop the service and provide management support at operational level.

The Mardon centre monitored outcome data through a national data collection for the purpose of benchmarking.

Are medical care services safe?

Requires improvement



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

We have rated safe as requires improvement.

Medicines were not always managed safely and according to best practice guidance to safeguard patients. This included administration and management of covert medicines such as disguised in food. Where patients were administering their own medicines, staff did not follow guidance and risks were not assessed to safeguard patients.

The resuscitation box was not tamper evident which may have posed risks as these could be accessed by patients or visitors at the service.

The Mardon centre was visibly clean and infection control procedures were in place to control and prevent the spread of infection to patients, such as the availability of hand sanitizers in reception and other points. Process and procedures were followed to report incidents and monitor risks. Staff were aware of their responsibilities in adhering to the duty of candour.

Staff had knowledge about safeguarding patients and actions they would need to take to protect patients in vulnerable situations.

Incidents were reported and feedback was provided following investigation as part of lesson learnt. There were mostly adequate nursing staff; although the registered nurse cover in the afternoon had been reduced since October. There were not always adequate therapy staff to consistently meet the needs of the patients.

Incidents

- There had been no incidents of "Never Events" associated with the unit, these are incidents determined by the Department of Health (DH) as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Medical care

- Incidents and accidents were reported using a trust wide electronic system, all staff had access to this and understood the incidents that required reporting.
- There was a speciality governance meeting that shared learning from incidents, risks, complaints and concerns. Minutes from these meetings were circulated and discussed at staff meetings. Clinical teams attended mortality and morbidity meetings that were held for the medical division. However staff knowledge and awareness of learning from both local and wider trust incidents was limited.
- For example, following an incident a staff member told us a review of the resuscitation equipment was being looked into. However staff were unable to provide evidence and outcome of the investigation. There was no root cause analysis available. No action plan had been developed to ensure learning from the incident was shared and risk of reoccurrence minimised.
- Some staff were aware of the quarterly trust newsletters in which lessons learnt were shared from other services. However, not all staff were aware of learning shared from other areas across the trust. Therapy staff told us this was variable, although this had improved with the new information sharing system.
- Staff used the “Comm cell” which is an internal system communication board, which the staff used to discuss various issues affecting standards of care such as changes in patients’ conditions. Staff said this was a positive step in improving communication across the unit.

Duty of candour

- The Duty of Candour legislation which came into effect in November 2014 requires healthcare providers to disclose safety incidents which result in a level of harm classified as death, severe, moderate or prolonged psychological harm. These incidents must be investigated and reported to the patient, and any other ‘relevant person’, within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Staff we spoke with had varied understanding of this legislation of the Duty of Candour and they had not received training about this. However they all said they were encouraged to report incidents.

- The trust’s internal electronic reporting system had a function which meant the investigator had to consider duty of candour when any incident of moderate harm and above occurred.
- The trust told us any moderate or above incident triggered a set circulation list within the relevant division. The trust and the relevant governance manager would follow through to ensure duty of candour had been followed.
- The trust’s Incident Review Group also monitored compliance with the duty of candour. Between March 2014 and the June 2015 there were 19 incidents for the Medical Services Division which met the duty of candour criteria for investigation. The duty of candour was initiated following a patient’s fall at the centre. The investigation report was shared with the patient and their representative and included an apology.

Safety thermometer

- The trust collected safety thermometer data in relation to care provided to patients. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections and falls. Safety thermometer information provides a means of checking performance and is used alongside other measures to direct improvement in patients’ care.
- Information about safety thermometer was collected at Mardon; however this was not visible and staff were not aware of the findings. A senior member of staff told us they were not aware that this information should be available to patients and others.
- Safety thermometer data showed there was a low prevalence of pressure ulcers. There were two pressure ulcers of grades two and three for September 2015. However, these were patients who had been admitted to the centre from other wards and another hospital. The trust also monitored catheter urinary tract infections and catheters inserted over 28 days. At times the incidence of patients with a urinary catheter over 28 days on the unit was high. This was due to patients having long term catheters due to their neurological condition. In August 2015 Mardon had five catheters over 28 days and one new urine tract infection.

Cleanliness, infection control and hygiene

Medical care

- The unit was visibly clean and infection control procedures were in place to control and prevent the spread of infection to patients
- The Department of Health publishes the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance. The Code sets out the criteria against which the CQC will judge a registered provider on how it complies with the cleanliness and infection control requirements.
- Policies and procedures had been developed for the control and prevention of infection. These included regular audits to assess their compliance and action plans developed to manage shortfalls as required.
- Staff and visitors were able to easily access hand sanitisers with these being available in reception and other points. We observed staff following hand hygiene procedures such as washing their hands and using sanitising gels in between patients in line with trust policy. The trust had set targets for hand hygiene compliance audits and rated 85% as amber and 90% as green. The Mardon Centre had achieved 95% compliance in the last four hand hygiene audits which showed compliance rate was good.
- The trust had reported no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) blood stream infection since 2011, and no Clostridium Difficile (C .Diff) in the last three years which related to Mardon unit.
- An environment daily cleaning checklist was completed to monitor and assess compliance with daily cleaning and this was adhered to.
- Patient Led Assessment of the Clinical Environment (PLACE) audit 2014/2015 showed the Mardon unit with a score of 96% for cleanliness and 91% for the environment.

Environment and equipment

- Staff had access to emergency medicines in the event of a cardiac arrest. However the resuscitation box was not maintained securely in line with trust's policy. The box was open and not tamper evident which posed risk of unauthorised access to equipment and medicines or that the required medicines may not be available when required.
- The staff said the resuscitation equipment should be checked weekly and we saw records that these checks were maintained.
- A random check of syringes in the treatment room showed there were six blood taking syringes which had

expired in September 2015. This may have posed risks as these syringes may not be fit for purpose. We brought this to the attention of the nurse in charge and these were removed. Staff told us there was no system for checking stock items.

- The Mardon unit was purpose built and accommodation was provided in single rooms with adaptations which were appropriate and met the needs of patients.
- Patients were complimentary about the accommodation provided and confirmed they had the necessary equipment needed. A patient told us about an adapted frame they had started using which had helped their mobility.
- As the purpose of the unit was to provide a rehabilitation service to meet individual needs there was access to a variety of equipment, such as specially adapted wheelchairs, baths, beds and walking frames to support and maintain patients' independence. This included specialised equipment which was accessible and according to patients assessed needs. A patient was provided with an adapted frame which they told us had been "very good" and had improved their mobility.
- A random check of equipment showed these had been serviced regularly in line with the trust's policy. Electrical equipment had portable appliance test (PAT) completed to ensure they were fit for use.
- The League of friends provided support to the centre and had recently purchased two wheelchairs and two beds which benefitted the patients as they had equipment to meet their needs.

Medicines

- Staff did not always manage medicines safely in line with policy.
- We were concerned that staff were administering some medicines covertly, disguising this in a patients drink. The trust medicines' policy showed that the decision to administer medicines covertly must involve a multidisciplinary team, including at least a doctor and a nurse and, where possible, a pharmacist. Where covert medicines is considered there are national guidelines regarding administration of medicines as crushing medicines may alter the way the tablet or capsule works. For example, when crushed the absorption of the medicine may be quicker than intended and lead to side effects. The decision to administer medicines covertly and how best to achieve covert administration

Medical care

must be clearly recorded in the medical notes and the decision must be regularly reviewed. There was no evidence that staff were following this or were taking into account best practice consent and considering a mental capacity assessment in line with the trust's policy. There was no evidence staff had considered the least restrictive option and having due regards to the patient's basic rights and freedom (Human Right Act 1998) when administering covert medicines. The trust had confirmed there was no separate covert administration procedure or guideline available to inform staff's practice.

- Staff did not always follow the trust's own procedures for medicines administration. The standard operating procedure (SOP) and assessment for covert medicines which was in a patient's note were from Devon Partnership trust. This may differ from the current trust's SOP as was not approved by the trust.
- The staff did not follow their procedures to ensure medicines were disposed of and returned to pharmacy in accordance with the trust's policies and standard operating procedures. There was a large box of medicines which staff said had been there for over six months and had not been returned to pharmacy.
- One patient had been administering their own controlled drug to manage pain effectively. A decision to withdraw the medicine was made following pharmacist's advice as the patient had become very drowsy. During the time the patient had been self-medicating there was no evidence of a risk assessment being undertaken to ensure the patient was managing this safely.
- The Mardon centre had a first aid box which also contained two types of pain tablets. Records showed staff were dispensing these tablets to other staff members and this posed a risk as the staff may have an adverse reaction to these medicines.
- We received conflicting reports about the storage of an emergency drug in the resuscitation box which may have caused delay in accessing this if required. This was resolved on the second day of our inspection.
- Medicines were stored in dedicated refrigerators and the refrigerator temperature was monitored daily which included the minimum and maximum temperature. Records we saw all showed the temperatures to be

checked and within the required range. This meant staff were able to see when the refrigerator temperature was either above or below the normal range and action could be taken as needed.

- Other medicines were stored in a cupboard in the staffroom. The nurse in charge confirmed they were not able to monitor the temperature of the room where these medicines were stored. These included creams, ointments, liquid medicines and tablets. Medicines not stored according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients.
- Patients told us they were able to receive their medicines when they needed them and this included pain control tablets.
- We viewed the controlled drug (CD) registers and found these to be appropriately completed, with weekly CDs checks and CDs were kept securely.

Records

- Records were seen to be stored securely and were accessible. We reviewed six medical, nursing notes and other associated records and found the quality and legibility to be good.
- The unit used a combination of paper and electronic system for patients' records. Access to electronic records was password protected which staff said was secure.
- Patients had a comprehensive pre-assessment which was recorded in the pre-assessment care pathway document prior to patients moving into the service. We saw the records were completed appropriately including risk assessments and care plans were in place. These included detailed therapists input and goals. Medical records were up to date and provided detailed information on the patients care and treatment.
- Individual care plans were developed which included regular reviews and mapping of rehabilitation progress which were discussed at clinical reviews.
- Detailed records were maintained at the weekly multi-disciplinary team (MDT) meetings which included assessments of risks, goal setting and action plans.
- Records contained information following reviews and assessments from other healthcare professionals to inform staff's practices.

Safeguarding

Medical care

- Staff in the unit, including non-clinical staff, were aware of what constituted abuse and the actions they would take and how to report issues to protect the safety of patients in vulnerable situations.
- Staff would report to the matron and some were confident to report higher up if they felt action had not been taken or needed to be taken promptly.
- Staff were aware of the trust whistle-blowing policy and we were told they could find information on the trust's website.
- There were safeguarding policies and guidelines for the protection of vulnerable adults. Safeguarding adults training was part of the trust's mandatory training programme. The current training data from the trust showed 97% of staff had completed safeguarding adult training against the trust target of 100%.

Mandatory training

- Staff told us they undertook a three day mandatory training when they joined the trust. This included a range of topics such as fire safety, health and safety, basic life support, safeguarding, mental capacity, manual handling, infection control/ hand hygiene, conflict resolution, consent and information governance training.
- The data provided by the trust showed compliance with mandatory training varied across the service. Staff at Mardon had achieved 100% compliance with equality and diversity and infection control training. However data showed that the percentage of staff who had completed training in conflict resolution was 55%, fire training and infection control 90% and moving and handling 83%.
- All staff with access to NHS patient information should undertake information governance (IG) training. Data from the trust showed 86% of staff had completed this training against a trust target of 100%.
- The Mardon unit did not have 24 hour medical cover such as a doctor on site. Patients suffering a cardiac arrest, for example, would be reliant on nursing staff to provide basic life support (BLS) until help arrives. A senior nurse told us staff had completed BLS training, but the trust had not been able to provide a breakdown of data to confirm this. The lack of oversight on training may impact on care and treatment as staff may not have the skills and confidence to provide this level of emergency care.

Assessing and responding to patient risk

- The Mardon unit was a low risk patient ward away from the acute hospital. This meant that staff would have to call 999 in the event of an emergency and possibly transfer a patient to the main site emergency department. Staff were confident and said they followed their procedure in accessing emergency support if needed.
- Due to the nature of their condition at times there may be patients on the unit who require mechanical assistance with breathing such as Bilevel Positive Airway Pressure, (BiPAP). This is a form of treatment for patients suffering from respiratory conditions where patients use a breathing mask at night to maintain their airway and are attached to a machine. We were concerned whether staff had the skills to manage these patients and were told while staff did not have specific training in the use of BiPAP, the unit only accepts patients using this equipment if they are able to manage it themselves. Support would be available to staff from Culm respiratory ward in the event of a concern or the respiratory nurses would also visit.
- Staff did not use the early warning score (EWS) to assess a potentially deteriorating patient, which was due to the service being a rehabilitation unit. Baseline observations such as temperature, blood pressure were taken when patients were admitted and this would be repeated if the patient became unwell. There was a risk this may not be escalated in a timely way. Staff said they would escalate to the medical team or could call 999 and transfer the patient to the accident and emergency department.
- Risk assessments were undertaken for individual patients in relation to falls, malnutrition and pressure ulcers. The trust used the Extra Pressure Risk Assessment tool (ESPRAT) for patients' pressure risks assessments. Actions to mitigate the risks identified were instigated such as provision of pressure relieving equipment.
- Patients were assessed for falls risks. Those who were assessed as low risk of falls did not have a care plan. Staff said this was normal practice for the centre. The trust audit on falls showed that the centre was not meeting the below 85% reduction in falls. Matron told us patients were at higher risks of falls as the centre was a rehabilitation unit. An assessment of patient's fall risks was undertaken and care plan developed for those

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deemed as high risks. Staff monitored patients as part of their intentional rounding, call bells were available and patients were encouraged to ask for help when mobilising.

- Occupational therapists undertook assessments of patients' home environment, and identified risk of possible hazards where appropriate. We saw in one patient's records this had been carried out prior to their discharge.

Staffing

- Nursing staff numbers did not always meet the planned requirement and therapy staffing levels were not in line with national standards.
- There are nationally defined minimum safe staffing levels for inpatient care wards. These include Safe Staffing: A Guide to Care Contact Time (NHS England, November 2014) and Direct Care Measurements (NHS England, January 2015). Staffing at the centre was reviewed every six months as part of the trusts establishment reviews. They used the British Society of Rehabilitation Medicine (BSRM) standards for rehabilitation services mapped to the National Service Framework (NSF) as these were appropriate to the unit.
- Shifts were agreed in advance against the planned registered nurse to patient ratios required for each shift. Since October 2015, staff told us and we saw the duty roster showed, there were occasions when there was only one registered nurse for part of the afternoon /evening shift. We received mixed views from the unit staff regarding the recent levels of registered nursing staff for late shifts. Patients told us they mostly received adequate nursing support. We noted two patients had been identified as requiring 1:1 support and this was provided to ensure the patients' safety.
- The unit used the trust's bank staff to cover shortages, although they had problems getting staff from the main trust to support them. Any shifts that could not be adequately staffed on the rota were escalated. Data for October 2015 showed eight shifts for specialising patients had not been filled on request.
- The national guidance for therapists (Royal college of Physicians 2003) guidelines for managing patients with acquired brain injury, state there should be one occupational and physiotherapy plus support staff for five beds. For the 12 beds on the unit the current physiotherapist staffing was 2.1 whole time equivalent (WTE). Occupational therapist was 1.88 WTE.

- Patients felt there was not always adequate therapy staff and this impacted on the level of occupational and physiotherapy they received. A patient said they had three half hour sessions of physio in a week. Therapy staff confirmed staff shortage had impacted on the level of therapy time patients received.
- Staff used the British Society of Rehabilitation Medicine guidelines in relation to the number of therapy staff needed to provide effective care and support for patients. Therapy staff undertook a review to show the impact of Speech and language therapy (SLT) staffing pressures and clinical contacts at Mardon from January to September 2015. This showed a marked decrease of clinical contact with patients from 500 units in January to 200 units in September 2015. A Band 5 staff member was funded for a year and this had terminated in March 2015. The current Band 7 therapist worked three days a week and also provided support to patients on the neurology ward at the trust. Staff told us this had an impact on patients with a reduction of time spent with patients. Staff told us not all of the patients were assessed on admission and a reduced speech and language therapy input for patients. They were also unable to undertake visits in the community for "vital life skills". At times therapists were also "pulled" to support the team on the acute wards at the trust which had an impact on patients receiving the required levels of rehabilitation at Mardon.
- The number of vacancies across the Medical Services Division was 28.23 WTE which included high levels of Allied Health Professional's (AHP) vacancies. The shortage of therapists had been highlighted on the trust's risk register.

Medical staffing

- The Mardon unit was consultant led. The consultant Neurologist provided half a day cover per week. The consultant attended the unit once a week on Wednesdays and took part in MDT meetings. Patients were reviewed and included discharge planning meetings with involvement of relatives as appropriate. However staff had access to registrars and the consultant could be contacted for advice and support.
- Neurology registrars provided cover between 9-5 pm and visited the unit on Mondays, Wednesdays and Fridays. Out of Hours was covered by Devon Doctors.
- Staff told us there were some issues with Registrar's cover when one of them was on leave which meant

Medical care

patients were not routinely reviewed. At these times staff contacted the on call trust's team for urgent cases or accessed out of hours cover which could at times impact on patients' care. This meant transferring patients to the accident and emergency department, when the treatment could have been provided on site.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents and staff would follow the trust's contingency plan. The unit accommodation was provided on the ground floor and exits were clearly signposted.

Are medical care services effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes,

Promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) and the British Society Rehabilitation Medicine standards and guidelines.

Patients' pain was monitored and they received pain relief when they needed it.

Patients who were at risk of malnutrition or had swallowing difficulties were supported by appropriately trained and competent staff. Assessments were completed by speech and language therapists and plans of care developed.

Patients' consents were sought prior to care and treatment. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Multi-disciplinary reviews were undertaken for patients who were under DoLS to ensure their rights were safeguarded.

Evidence-based care and treatment

- Patient needs were assessed and care and treatment was delivered in line with National Institute for Health

and Care Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers and malnutrition assessments.

- The British Society of Rehabilitation Medicine Standards (BSRM) for care of acute brain injury and rehabilitation of adults were used. These followed the national framework guidance and staff were aware of these guidelines.
- Therapists used a patient centred approach in the assessment and therapy-focused goals with patients and their family involved in the goal setting at all times. The Functional Independence Measure/Functional Assessment Measure (FIM/FAM) tool was used in the assessment of patients which looked at the physical and psychosocial functions which were often the main factors limiting outcome in brain injury patients.
- Therapy staff used the Rivermead index tool to assess patients' functional mobility. This is a tool specifically developed for patients who had neurological deficits.

Pain relief

- Patients told us they received pain control when they required them. Patients' pain was assessed and advice sought from a pain specialist from the trust as needed.
- We noted during there was a multi-disciplinary approach to pain assessment which included input from the clinical psychologist in achieving the best outcome for patients.
- Patients who were prescribed pain control, including controlled medicines, received them in a timely way.

Nutrition and hydration

- NICE guidelines were used as part of assessments which included the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. This was used during a patient's initial assessment in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- Patients were complimentary about the meals and comments included "very good food". They said choices were available including alternative meals from the main menus. However some patients told us the variety of the food could be improved as some patients were there long term and meals could be more varied.

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- Patients had access to fluids and snacks in between meals. Patients who were at risk of malnutrition were assessed by dietitians and actions taken to meet their nutritional needs.
- We observed patients received support with their meals in a respectful way and were encouraged to eat independently and supervised if needed.
- Speech and language therapists carried out thorough assessments and used care plans to ensure patients continued to receive food and fluids safely. Adaptations such as “chin tuck” therapy were used to support patients who had difficulty swallowing and enabling them to receive their diet and fluids safely.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the trust at 88% for quality of food which was comparable to the England average.

Patient outcomes

- From December 2013 to November 2014; there were 5 readmissions to Mardon Neuro-rehabilitation Centre from the 72 patients admitted. Low standardised relative risk of readmission was noted for the unit.
- Data from Hospital Episodes Statistics (HES) for Mardon showed for 2014/15 the Median was 8.5, Mean 30.26 and 44% have a LOS of 2 days or less. This meant that a large percentage of patients stay for 1-2 days, but some stayed for much longer.
- The length of stay data was not reliable as each time a patient was transferred for treatment to the main trust they were readmitted to the unit. This included if a patient went to the ward at the trust for treatment which lasted a couple of hours such as for an infusion. In effect a patient who had been in the unit for over 25 days was recorded as being there for two days.
- Mardon took part in the UK specialist Rehabilitation Outcomes Collaborative (UKROC) which was set up in September 2008 through a Department of Health initiative to develop a national database for collating case episodes for inpatient rehabilitation. Participation had been annually and showed the centre performance against the national data for referral to assessment, referral to admission which were greater than the average of other units contributing to the collaborative.

Competent staff

- There was a trust induction programme for all new staff and those who had attended this programme felt it met their needs.

- The department did not have an educational facilitator in place and the funding to recruit one was being discussed.
- Staff told us they had regular annual appraisals; however the data provided by the trust demonstrated that appraisal completion rate varied. Information received from the trust showed nurse's band 5-6 had achieved 81.2% and nurses band 7-8a-c 75%. Although Mardon centre had some appraisal ratings displayed, a senior member of staff told us these were not accurate as they had not been updated.
- Staff undertook role specific training to maintain and develop their skills. Advanced practitioners included a pain specialist to offer advice and support to patients and nurses.
- Allied health professionals (AHP's) held monthly meetings where staff could discuss complex cases.
- Health care assistants had completed training in self-catheterisation to support patients. These staff had their competency assessed to ensure the procedure was carried out safely.
- Therapists received regular supervision and they said this was effective. Nursing staff told us they did not have supervision and none of them were able to tell us about trust process to monitor and develop practices such as Care Matters, a forum where The Reflective Toolkit for nurses, midwives and allied health professionals was developed. Schwartz rounds which are open to all staff providing an opportunity for reflection. Ward based approaches are supported by matrons being supervisory to shift (60%) enabling them to work with nursing staff and reflect in practice.

Multidisciplinary working

- Internal multi-disciplinary working (MDT) was well established and formed an integral part of care in the Mardon Centre.
- Patients' records showed they were referred, assessed and reviewed by a multi-disciplinary team (MDT) such as physiotherapist, dietitians, speech and language therapists, learning disability, and continence teams.
- Weekly multi-disciplinary team meetings were held on a Wednesday. We attended part of the MDT meeting and observed good interdisciplinary working which was patient focused and plans were devised to

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ensure patients received effective care. The team comprised of therapists, physio and occupational therapists and speech and language therapists, nurses, psychologists and doctors.

- Pharmacy support had not been available for nearly a year which staff said had been “difficult”. This had impacted on the way that medicines were managed such as staff were unsure about safe disposal of medicines. Since October pharmacy support had been put in place and staff commented this was a much needed service.
- Records viewed identified family involvement as necessary for effective discharge planning and referral to the community support teams.
- Physiotherapy and occupational therapy took leads in patients’ discharge planning and liaised with the community teams, and GPs to ensure continuity of care post discharge.
- Patients had access to specialist nurses such as pain and continence assessors.
- Access to a psychiatrist and referrals were made as appropriate.
- External multi- disciplinary working was also well established with transfers between other trusts and specialist care and treatment.

Seven-day services

- Patients received 24 hr nursing care and medical support was available during the hours of 9-5pm from the trust. Out of hours medical assistance was provided by Devon doctors.
- Any emergency would require the patient to be transferred to the accident and emergency department at Wonford Hospital.
- There were no physiotherapy and occupational therapy service at the weekends which some patients felt could be improved. Rehabilitation should be a 24-hour process, with agreed goals and activities. The nursing staff supported patients in the continuation of their rehabilitation goals when therapists are not on duty. Nursing said they provided some support to patients with their exercise regimes at weekends. There was no plan to implement seven day therapists service in the future.

- The pharmacy department was open seven days a week, but with limited hours on Saturday and Sunday. An on-call pharmacist was available to dispense medicines and offer urgent advice over the weekends.

Access to information

- Staff told us they had good access to patient-related information and records whenever required. All staff had access to patients’ care records to enable them to provide care and support. The electronic patients’ information document was available to the multi-disciplinary team which contained detailed information relating to patients’ action plan and goal setting.
- There was a patient transfer summary in patients’ notes for those who were transferred within the hospital and this ensured continuity in the patient’s care.
- Discharge was pre planned and discharge letters were faxed to GPs on the same day to inform them of their patient’s medical condition and the treatment they had received. Patients were also issued with a copy on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Patients were asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were followed to ensure decisions were made in the best interests of patients. Two doctors were able to describe action they would take if patients did not have capacity to consent such as best interest decisions and involvement of relatives or friends as appropriate.
- Records for a patient showed a detailed capacity assessment had been completed with a multi-disciplinary team approach. This included assessment with input from a psychologist and speech and language team.
- There was one patient who was under a deprivation of liberty safeguard (DoLS) at the time of our inspection. Staff had followed their process such as a referral was made to the local authority team for assessment. A recent review of the DoLS application had been completed which meant staff were aware that DoLS were time limited to safeguard patients.

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- Patients' records showed mental capacity assessments were completed and this was also audited on a monthly basis using their treatment escalation plan which showed they were compliant.
- We observed staff asking for patients' consent when providing support and giving explanations in a clear and unhurried way.
- Patients told us clear explanations about their care and therapy had been discussed with them and they felt involved in their care.

Are medical care services caring?

Good



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

We rated caring as good.

Staff provided compassionate care and ensured patients were treated with dignity and respect when supporting them. Patients were positive about the care and treatment they were receiving.

The multi-disciplinary team were motivated and care was patient focused. Patients and their relatives felt involved in the care and decision making and care was centred on their individual needs.

Staff rated patient's emotional needs highly and these were embedded in their care and treatment. We observed that staff were responsive to patients' needs, and provided emotional support to patients in a calm and respectful way.

Compassionate care

- We spoke with seven patients and relatives during the inspection. All patients said that the multi-disciplinary team provided them with "very good" care and support and a good and caring service.
- We found staff provided care with empathy, understanding and compassion. The staff and patients had developed good relationships with patients and their relatives.
- Staff were passionate and committed about the care and treatment they provided and we observed positive and caring interactions with patients.

- The NHS Friends and Family test results for Mardon showed that 95% of patients would recommend the trust as a place to receive care and treatment which was similar to the national average. However this result was dated 2011 and we do not have any recent survey.
- We observed multiple examples where staff demonstrated compassionate and kind behaviour towards patients. Staff in multidisciplinary meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.

Understanding and involvement of patients and those close to them

- All the patients we spoke with felt well informed and involved in the decision making regarding their care and treatment. They were able to discuss their plan such as physiotherapy and occupational therapy and found the team was supportive. One patient reported that staff discuss what is going on with their exercises and another patient reported that they see the physiotherapist every day and were given a new frame which has been beneficial.
- We observed sharing information to patients and families in a way they could understand. Staff employed different techniques to ensure effective communication. Staff recognised when patients required extra support to be able to become involved in their treatment plans.
- Both patients and their relatives commented that information was discussed in a manner they understood. Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regard to the way they had been spoken to, and all were complimentary about the way they were treated.
- Relatives told us they received support from the staff and were involved in the care of their relatives as appropriate.

Emotional support

- The MDT team also consisted of clinical psychologists who provided treatment and support in the unit. Patients said they felt this was a valuable service and had helped them in their recovery.
- Throughout our inspection we witnessed patients being treated with dignity and respect. We observed staff communicating with patients in a respectful way. We observed a staff member supporting a patient who

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became distressed as they were not able to make themselves understood. The staff remained focused on the patient and allowed them time until they worked out the patient wanted to go back to their room.

Are medical care services responsive?

Good



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

We rated responsive as good.

There were good examples of multi-disciplinary working which was responsive to meet the needs of local people. Admission criteria were followed to ensure patients were at the right place for their rehabilitation. Although discharge planning was initiated early, this was not always effective as patients remained longer at the centre due to lack of community places.

Support was available for patients working closely with other local teams to meet the needs of patients in vulnerable circumstances.

Complaints were handled in line with the trust's policy. The trust told us some complaints took some time to respond due to their complexity. Patients we spoke with felt they would know how to complain if they needed to. Staff received feedback from complaints and these were discussed at team meetings and were learnt from.

Service planning and delivery to meet the needs of local people

- The Mardon centre provided specialist care to patients with facilities specially adapted to meet the rehabilitation needs of patients following brain injury.
- Guidelines for implementation of the National service Framework (NSF) recommend that service providers and commissioners should work together to increase capacity in rehabilitation services, both in hospital and the community which will help to relieve pressure on acute beds. Staff told us there were capacity issues which impacted on patients who were waiting for a bed at the service. There were two rooms which had been

completely refurbished which staff said had not been used with no specific plan in place for when they would be open for patients. The trust has since told us they were working with commissioners to resolve this.

- There was a dedicated bed used for functional assessment patients such as fatigue, lack of sleep and psychological symptoms. These patients were admitted for a set period of four weeks; however this was not effectively achieved due to bed availability and long stay patients.
- Mardon centre carried out sleep studies three days a week. This was currently suspended due to an equipment fault which impacted on the service for patients. The staff could not tell us about when this would be reopened.

Access and flow

- There was a clearly defined admission criteria to the unit such as patients should have a primary neurological condition, be over 16 years of age and not in full time education. Referrals were received from the acute and community MDT teams. GPs contacted the consultant neurologist and all referrals were discussed as part of the weekly MDT meetings.
- Assessments were carried out within a week of referral in line with the centre's standard operational procedures. The process was for the therapists to assess patients within six days following referrals and this was being met.
- Staff told us the bed occupancy at the Mardon centre was above 90% for the majority of the times. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. There was no data available in relation to bed occupancy for Mardon.
- We were told that the main cause of delays for discharge were the complexity of patients' needs and the provision of community services. Some of these included care home placements, to meet patients' on-going needs. The withdrawal of community beds had impacted on patients' discharge.
- Currently throughput to Mardon was very slow and patients who would benefit from rehabilitation remained in acute beds. Staff told us some patients were discharged home while they were waiting for a rehabilitation bed. There were four patients who had been at the centre for between nine months to a year.

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Staff told us this had a major impact on delivering a rehabilitation service. This impacted their ability to admit referrals from the neurology acute ward at the trust.

Meeting people's individual needs

- All the patients were provided with single accommodation which patients said met their individual needs. The centre had been designed and provided excellent facilities for patients with limited mobility. The corridors were spacious and patients had level access and safe ground outside. There were specific adaptations and designated physiotherapy and occupational therapy rooms to meet the needs of the patients
- A wide range of patient literature was displayed in clinical areas and included disease and procedure specific literature, health advice and general information relating to health and social care and services available locally. Patient information leaflets were not displayed in languages other than English. However the trust had an interpretation and translation service and face to face interpretation and translation was available including Braille.
- Staff had access to the learning disability team who were responsive and we saw assessment and plans of care had been developed.
- There was a chaplaincy service and details of prayer services were displayed at the centre. Training was available to staff in spiritual care and awareness training for new auxiliaries, preceptorship and return to nursing colleagues.
- The Trust was finalising a spiritual care policy to support this good practice for all patients and ensure that the hospital chaplaincy guidelines were followed.

Learning from complaints and concerns

- Complaints were handled in line with trust policy, and staff showed us that patients were given information on how to complain. Staff directed patients to 'Patient Advisory Liaison Service (PALS)' if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- Patients expressed a high degree of satisfaction with their care and said they were able to raise any concerns.
- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint, formally or informally.

- Where patient experiences were identified as being poor, action was taken to improve their experiences such as investigations and learning from complaints. A senior staff told us that any learning from complaint investigations was shared with the team at their "Comm cell" meetings.

Are medical care services well-led?

Requires improvement



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

We rated well-led as requires improvement.

There was a trust's strategy, this was not known at local level and embedded for the provision of a responsive service that delivered care as close to home as possible seven days a week.

Although patients and staff surveys were collected; there was no evidence to show how this impacted in planning and developing services.

There was a governance structure to manage risk and quality. Staff felt supported by their managers. The staff reported there was no lead at the service in order to drive changes and provide operational support. The trust has confirmed there was a clinical lead for Mardon who was based at the trust. Staff described management at local level as good and felt they were supported in their roles. Staff at the Mardon centre did not feel connected to the trust as a whole.

Vision and strategy for this service

- The vision for the service was to see Mardon build on its current position as an inpatient Neuro-rehabilitation Service.
- A senior manager told us the trust had identified the priorities for the service. The trust was planning to expand the service and providing more Neuro-rehabilitation beds at Mardon but also in community based settings including patient's homes where appropriate. However the current facilities such

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as two fully refurbished rooms were under-utilised and there were plans to reopen them. This had been escalated to a system resilience group in order to move this forward.

- The plan was to increase the consultant Neuro-rehabilitation cover and extend the service for spinal injured patients, Functional Neurology Patients, and for more acutely unwell patients to start the rehabilitation process early and relieve the pressure on acute hospital beds. There was no firm date as to when this would happen.
- There was a plan to identify the opportunities for a dedicated hydrotherapy facility at Mardon as part of developing the rehabilitation pathways for patients and was yet to be agreed.
- All the above were aspirational. No firm action plan was in the place in order to achieve these objectives.
- Staff were not able to tell us about the trust's strategic visions and values and felt disconnected from the wider trust. However they were passionate about providing care and working at the unit.

Governance, risk management and quality measurement

- There was a clear governance structure and process in place, the neurology speciality governance group meetings took place on a bi-monthly basis, which included morbidity and mortality (MM). Also reporting on finance and performance and quality issues within the division. They looked at serious incidents, cases of hospitals acquired infection, compliance with hand hygiene audits, care and quality performance indicators.
- We saw, from minutes following these meetings, where a wide range of issues were covered including audit activity and results, patient feedback, staff training and finance.
- The Mardon centre monitored outcome data through a national data collection for the purpose of benchmarking against other rehabilitation services.
- Minutes of governance meeting from October 2015 showed that Mardon service continuity plan was being submitted to the divisional governance for sign off which was provided to us. Senior staff were not aware of a continuity plan for the service.
- The service had a risk register that included all known areas of risk identified for neurology. These risks were

documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated.

Leadership of service

- There was a well-established rehabilitation team and the Mardon centre had a nurse manager who provided day-to-day leadership to the staff. Staff felt well supported by their manager and said this worked well at local level. Staff told us senior management from the trust was not visible at the centre. They felt there was no lead to develop the service and provide management support at operational level.
- Staff commented there was no one in a leadership role to push changes. For example, underused resources such as beds which were not commissioned. Staff said they had tried to get a working group together to review services, but there was no support from senior management at the trust to push this through.
- Staff felt there was a disconnect between the 'centre' and they did not all consider themselves as part of the trust. Although they felt valued by their immediate managers and peers and told us they really enjoyed working at the centre with a strong focus on providing compassionate care.
- Two staff commented the centre was not forward thinking and averse to changes.
- Staff were aware of the whistle-blowing procedure and were confident in using it. Staff were proud of the multi-disciplinary approach and team work at local level which they said was very good.

Culture within the service

- Staff spoke positively and passionately about the care and the service they provided. There was an open culture in raising patients' safety concerns, and staff were encouraged to report any identified risks. Comments included "we are here for the patients"
- Staff said they felt like valued team members. They provided examples where they had been supported in acquiring new skills which benefitted patients.
- Staff felt proud to work for the Mardon centre. Staff, including student nurses, therapists, and doctors and housekeeping staff spoke passionately about their work and of being part of the team.

Public engagement

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- The centre had developed good links with the League of friends who supported them in caring for the patients. The league of friends was involved and supported the unit and had recently purchased some equipment for patients.
- There was a system in place to gather information from patients and their relatives. These were discussed on the “Comm cell” as “what you said” and “what we did, showing how staff had made changes in response to feedback such as meals and activities.
- The patient satisfaction survey from January 2014- April 2015 showed 62% of patients felt the rehabilitation programme was tailored to their needs. 68% of patients said the rehabilitation addressed their specific physical disability. Patients were less positive about other factors of their care such as 57% felt progress reviews were helpful and 56% were with doctors input. There was no action plan developed to address the shortfalls identified in the survey.
- The 2014 NHS staff surveys showed 91% of staff felt the trust provided opportunities for career progression. This indicated that 68% of staff felt they contributed to improvement at work and 67% were confident to report concerns about unsafe clinical practice. Only 28% reported there was good communication between senior management and staff. 11% said they had suffered discrimination at work and 20% reported harassment and abuse from other staff. Staff were not aware if actions had been taken following the survey results. There was no specific survey data for Mardon.
- The trust had introduced ‘Comm cell’ to facilitate communication between the multi- disciplinary team. Staff used this for raising concerns around service delivery issues as well as feedback results of incidents.

Innovation, improvement and sustainability.

- There were plans for developing two private beds and the resource from this would be used to develop the service. This was currently under discussion and no firm decision had been reached.

Staff engagement

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure medicines are administered to patients safely in line with policy and take into account their rights.
- Ensure medicines are disposed of and returned to pharmacy in accordance with the trust's policies and standard operating procedures.

Action the hospital **SHOULD** take to improve

- Ensure there are sufficient therapy staff deployed in order for patients to receive consistent care and according to their needs.
- Ensure incidents are investigated and records are available with a robust process for disseminating information to all staff following incidents investigations.

- Ensure discharge planning processes are pro-active and well co-ordinated to reduce delayed transfers out of the centre.
- Ensure service strategies are clear and communicated effectively and development plans for the service are identified.
- Identify a lead to develop the service and provide management support at operational level.
- Review feedback from patient surveys and develop action plans to improve patient experience.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014:</p> <p>Safe care and treatment</p> <p>How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment because:</p> <p>The management of covert medicines was not managed safely and effectively. Patients' rights were not respected. Policies and procedures were not followed for the safe management of medicines.</p>