Active Neuro Limited

Blackheath Brain Injury Rehabilitation Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The service had over 360 medicine errors in the 6 months prior to inspection. The biggest themes were medicines being out of stock and recording omissions. Meeting minutes showed these were discussed at clinical governance and team meetings. Some actions were taken to address medicines being out of stock. The provider had contacted the GP surgery about the medicines being out of stock from the 19 April 2022, and was communicating with the GP surgery to address this concern. However, an incident took place in October 2022 where a patient had been left without medicine for 7 days. Actions to address recording omissions included peer reviewing records to ensure no recording omissions. However, medicine audits showed errors were still happening.
- Staff did not always discharge their responsibilities under the Mental Capacity Act 2005 in a timely way. Two patients under deprivation of liberty safeguards (DoLS) had not had a further application made after their DoLS had expired. This meant the patients were unlawfully deprived of their liberty for several months
- Although the service had governance systems to assess and the quality and safety of the service, these systems were not always effective. The service had a site improvement plan to manage any identified improvements and actions from audits. However, these did not include many of the issues we identified during the inspection. The service had a quality assurance framework to help manage their audits. However, additional audits to monitor identified areas of concern had not been done monthly, as required. The service risk register did not reflect some of the risks we identified during the inspection
- While learning from incidents was shared at morning handover meetings, in team meetings and in clinical governance meetings, the ongoing medicine errors showed this learning was not always embedded
- The service did not have a formal process to collect feedback from patients, carers and families. This meant the service was not able to use this feedback to make improvements to the service. The service had a process to obtain feedback from staff in the form of a staff satisfaction survey. The most recent survey had been completed in November 2021. The survey for 2022 had been delayed as the service had changed their methodology, and this took place in January 2023
- The occupational therapy team had 6 vacancies with only 1 rehabilitation technician and an activities co-ordinator in post. There was a risk that patients were not getting the appropriate support in this area
- A few patients told us they were not always involved in the planning of their own therapy goals, or were not aware of their discharge plans
- One patient was concerned they had not been instructed in the proper use of a mobility aid
- Not all staff knew of the accessible information standard (AIS) which is a legal standard aimed at making sure people with a disability or sensory loss are given information they can understand in the way they would like it and their communication needs are flagged on their health records
- The premises were a smoke-free environment, but patients were supported to smoke in the garden. This meant that the service was not operating within its own policy or being mindful of national public health guidance
- Some patients told us that did not like the quality of the food. One patient said the food was bland and another patient showed us a photograph of burnt food they had received
- Staff annual appraisals were not always completed on time. At the time of inspection appraisals for the therapy team were at 63%, and for non-clinical staff 54%

However:

- Staff treated patients with care and kindness and encouraged them in their rehabilitation goals

Summary of findings

- Staff spoke highly of the managers and their team. The said there was good teamwork and support from the therapy teams and from each other
- The therapy teams developed holistic, recovery-oriented care plans informed by the initial risk assessment.
- The wards were fully staffed with nurses and doctors. Staff assessed and managed risk well
- The service was engaged in a range of quality improvement projects.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Requires Improvement 	Please see the overall summary above for the summary of this service.

Summary of findings

Contents

Summary of this inspection

Background to Blackheath Brain Injury Rehabilitation Centre

Blackheath Brain Injury Rehabilitation Centre is provided by Active Neuro Limited. Blackheath Brain Injury Rehabilitation Centre in south east London is a provider of specialist inpatient rehabilitation for individuals with an acquired brain injury or other complex neurological conditions. Blackheath Brain Injury Rehabilitation Centre comprises of two wards and provides 39 beds for male and female patients. Thames Unit admitted patients with complex cognitive or behavioural problems following a brain injury or as a result of a neurological condition. Heathside Unit admitted patients with less challenging behavioural problems who had ongoing physical therapy needs. At the time of the inspection 34 patients were using the service.

Blackheath Brain Injury Rehabilitation Centre is registered with the CQC to carry out the following activities:

• treatment of disease, disorder or injury

• assessment or medical treatment for persons detained under the Mental Health Act 1983

Patients using the service are admitted from an acute hospital and most return to their own home after rehabilitation.

There have been nine previous CQC inspections of Blackheath Brain Injury Rehabilitation Centre when it was registered under a different provider, with a different name. Thames Ward was last inspected in August 2018 and there were no regulatory breaches identified. The service was rated as Good overall. Heathside Ward was registered and regulated separately until March 2021 and was last inspected in September 2019. There were no regulatory breaches identified and service was rated as Good overall. This service registered under this provider had not been inspected before.

The service had a registered manager.

What people who use the service say

We spoke with 8 patients and most of the feedback was positive. Patients told us what they most liked about the service was the kindness and encouragement of the staff. Patients told us they felt safe and had observed the staff being kind to other patients. Patients attended a weekly community meeting with the advocate where they were able to give feedback and request improvements for the service and themselves. However, some patients told us they were not involved in their care planning and they did not have a copy of their timetable. Patients gave us mixed feedback about the food. Some patients said it was fine, whereas other patients thought the quality of meals was poor.

We spoke to 13 carers and families. They had mixed views about the service. They told us the patients felt safe and were well cared for. However, carers and families did not always feel involved in the service, or aware of their relative's care. Families and carers told us communication with the service was not always easy and there was no process to give formal feedback. Families and carers told us they were unhappy that the hydrotherapy pool was not available for use.

How we carried out this inspection

During the inspection, the inspection team:

- conducted a review of the environment of the wards and clinic rooms

Summary of this inspection

- observed a clinical governance meeting, morning meeting, clinical review meeting and a lunch service
- spoke to the registered manager who was the hospital director of the service and the 2 ward managers
- spoke with 14 other staff members, including the head of nursing and quality, the consultant neuropsychiatrist, a ward doctor, the lead speech and language therapist, 2 physiotherapists, 3 nurses, one senior rehabilitation assistant and 4 rehabilitation assistants
- spoke with 13 family members and carers
- spoke with 8 patients
- reviewed 10 medicine administration records
- reviewed 8 patient records
- looked at a range of policies, procedures and other documents relating to the operation of the service

The inspection team consisted of a lead inspector, an inspection manager and two other inspectors.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that deprivation of liberty safeguard applications are made on time (Regulation 11(3))
- The service must ensure that the management and administration of medicines is safe, accurately recorded and patient medicines are in stock when needed (Regulation 12(2)(f)(g))
- The provider must ensure that learning from incidents is shared and embedded effectively to prevent re-occurrence (Regulation 17(2)(f))
- The service must ensure there is a formal process to collect feedback from patients, families and carers about the quality and safety of the service for the purposes of evaluation and improvement (Regulation 17(2)(e))
- The service must ensure the systems in place to assess, monitor and improve the quality and safety of the service are effective. (Regulation 17(1)(2))

Action the service SHOULD take to improve:

- The service should work with patients to improve the quality of the meals
- The service should continue to work on filling vacancies for occupational therapist and psychologist roles
- The service should ensure staff are aware of the 5 requirements of the accessible information standard
- The service should continue work to actively promote smoking cessation, and move towards becoming a smoke free environment
- The service should ensure all patients are aware of and involved in their care planning
- The service should ensure all patients are shown how to use and feel confident to use any mobility aids they are provided with
- The service should ensure staff appraisals are completed on time
- The service should ensure that the risk register accurately reflects the main risks in the service
- The service should ensure that areas used for examining patients comply with infection prevention and control policies

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Services for people with acquired brain injury

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

Are Services for people with acquired brain injury safe?

Requires Improvement

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff had easy access to alarms and patients had easy access to staff call systems. We saw that call buttons were placed close to patients so that those who were less mobile were able to reach them. All bathrooms and bedrooms had alarm call systems. Patients and staff said the alarm call systems worked.

The service complied with guidance on eliminating mixed-sex accommodation. Some rooms on both wards had ensuite bathroom facilities. Male and female sleeping areas were segregated except for one corridor on Heathside Unit where there was a male bedroom next to a female bedroom. Both rooms were ensuite and neither patient needed to pass the other's bedroom to reach a bathroom. There were separate female lounges available on each ward.

We observed staff were regularly on the main corridors and communal areas, providing therapy to patients, and providing care and support in their rooms. There was good staff presence in all areas, which helped with effective observation. Some rooms, such as the dining room, were kept locked on Thames Unit because of potential risks to patients. The risks affecting patients on the two wards were different due to differences in patients' stages of recovery and the effects of the individual brain injury.

The service undertook an annual ligature audit. The last audit was completed in August 2022. Ligature cutters were kept in the clinic room and staff knew where the ligature cutters were kept. The service's risk assessment in relation to the premises set out how ligature risks, including those from doors, bedroom noticeboards and windows were mitigated by staff regularly reviewing and managing risks to individual patients. The service only admitted patients who presented a low risk in terms of self-harm. Staff used observations and admission screening to mitigate risks.

The service undertook an annual fire risk assessment. The most recent fire risk assessment was on the 16 December 2021. The risks identified all had a management plan in place.

The service undertook a fire drill at least twice a year. The most recent fire drill was on the 8 November 2022. There were no concerns identified. Patients had a personal emergency evacuation plan, which was formulated on admission to the service. Staff were aware of the fire exit procedures. All staff were aware of how to evacuate and support patients in an emergency.

The service completed an environmental risk assessment every 6 months. The most recent environmental risk assessment was on 22 August 2022. The service had one outstanding action following this assessment. This was to ensure there were updated hard copies of polices stored at main reception. However, staff had electronic access to these policies. This action was escalated to senior management.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. We saw regular cleaning taking place during the inspection. Staff recorded when cleaning of rooms had taken place.

All patients had single rooms with appropriate furniture according to their needs. Communal bathrooms and toilets were visibly clean.

The ward managers completed monthly infection prevention and control audits for each ward. Staff followed infection control policy, including handwashing. Staff had a plentiful supply of personal, protective equipment on the wards. Plastic aprons and gloves were available outside patients' rooms, along with clinical waste bins. These were emptied regularly, and staff disposed of clinical waste in a larger bin outside the building. Staff wore face masks in clinical areas.

Information on infection prevention and control, infection risks and precautions were on display in the wards for all to see.

Clinic room and equipment

The clinic rooms had the necessary equipment for patients to have thorough physical examinations. The clinic room on Heathside Unit was small and did not have an examination couch or room for a chair. However, patients were able to be examined in their bedrooms, although patient bedrooms were not part of the infection prevention and control policy that covered clinic rooms.The clinic rooms were tidy and visibly clean. Staff made checks to ensure that medicines and equipment for use in an emergency were readily available. Staff knew where emergency medicines were and knew that adrenaline was stored in the clinic.

Staff checked, maintained, and cleaned equipment. Hoists, which were in regular use, were cleaned by staff between patients and again at night. A label was attached stating when the equipment had last been cleaned. All hoists had been serviced in the last year.

One patient reported that there were not always sufficient hoists available to enable them to get up to eat breakfast in the dining room. They thought this could be remedied by better planning, staggering the use of hoists for different patients or by obtaining another hoist of the required type.

Patients, carers and families complained that the hydro pool was not in use and had been out of action for the duration of their admission. The registered manager told us this was due to a part not being available and this had been communicated to the patients. A patient was concerned they had been provided with a walking aid by staff but not shown how to use it properly.

Requires Improvement

Services for people with acquired brain injury

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm.

Nursing staff

The service had enough registered nurses and rehabilitation assistants to keep patients safe. Staff reported appropriate staffing levels.

Staff felt there were sufficient staff on duty to care for patients safely.

The service had low rates of bank and agency staff. The bank staff use rate as of November 2022 for the last 12 months was 4% and for agency staff was 2.1%. The wards used bank and agency staff occasionally when staff were unable to come to work at short notice.

The registered manager could adjust staffing levels if staff were unable to come in, patients required higher levels of observation or staff were undertaking face to face training. The provider used an agency with a dedicated pool of agency staff available to ensure the service had staff familiar with the service. Both permanent and non-permanent staff confirmed that most bank and agency staff were regular.

The staff sickness rate for the service was low, as of November 2022 for the last 12 months this was 2.9%. Managers supported staff who needed time off for ill health. Most staff confirmed support and flexibility around sickness and wellbeing.

Patients reported that there were enough staff on duty each shift to support them. They reported that call bells were responded to promptly.

Each patient had a named therapist and an individual therapy timetable each week. Patients had regular one-to-one sessions with their named nurse. Patients said they could have one to one time with their named nurses most of the time, and could speak to any member of staff when needed.

Patients told us that planned sessions usually took place as per the timetable but were occasionally cancelled if a member of staff was unexpectedly absent. One patient said that at times escorted leave was postponed to a later time due to staff supporting others or doing other tasks.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank and agency staff had an induction before their first shift with a nurse or senior rehabilitation assistant, and this was repeated every 28 days. The agency staff were knowledgeable regarding brain injury rehabilitation services and the specific support that was required such as focusing on mobility, activities of daily living, and interest activities. Patients confirmed staff supported them in these areas and this was linked to their care plans. Staff and patients felt the skill mix was right with patient reporting staff helping them in all their recovery areas.

Staff shared key information to keep patients safe when handing over their care to others. Staff said they discussed any changes in patients' needs, support and presentation at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings.

Requires Improvement

Services for people with acquired brain injury

Medical staff

The service had enough medical staff. Staff and patients said they could access the consultant and doctors when they needed to. The medical director was the consultant neuropsychiatrist for the service. The service also had a consultant neurologist and two ward doctors. Patients were registered with a local GP who attended the service each week. Out of hours staff called NHS 111 or emergency services. The consultant neuropsychiatrist told us they were always available via phone or email.

Mandatory training

Staff we spoke with said they had completed and were up to date with their mandatory training. They would get an alert or prompt from the manager when their training was due. The completion rate for mandatory training was 84%. As of October 2022 the training rate for Managing Medications was 68%.

The mandatory training programme was comprehensive and met the needs of patients and staff. This included fire safety, basic life support and ligature awareness training. The registered manager monitored mandatory training during clinical governance meetings, and staff were alerted at team meetings and through email when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment and management of patient risk

Patients were referred into the service from acute hospitals. The service used a pre-admissions checklist to collect risk information. This included mood and behaviour as well as physical health risk such as pressure ulcers, foot health and oral health. The consultant neuropsychiatrist would then visit the patient on the acute ward and assess whether the patient was appropriate for the service. The service did not take patients that had a risk of violence, suicide, substance misuse issues or were forensic patients. The consultant neuropsychiatrist then completed a clinical risk inventory for each patient on admission. The named nurse and therapy teams formulated care plans for each risk, using a recognised risk assessment tool, and these were reviewed monthly or when there was change in risk. For example, when a patient started to become disinhibited this was documented, and the use of enhanced observations and distraction techniques were used. Additionally, on admission of a patient staff carried out a fall's assessment, malnutrition screening, a daily living assessment, a waterlow assessment to estimate the risk of pressure ulcers developing, and a bed rail assessment.

Risk assessments were recorded on a standardised form in the patient record. This form included the patient's medical history, their specific brain injury and potential related risks and mitigation to reduce the likelihood of incidents occurring. Staff said each risk assessment was specific to the patient and gave details of how staff could support patients to respond to these risks. Staff recognised when to develop and use behavioural support plans according to patient need. The staff team planned how to manage risks at the daily handover, and this information was then shared at the daily multidisciplinary meeting. When necessary, the staff team adjusted staff numbers so patients could be observed on a one to one basis to reduce risks.

Staff responded promptly to any sudden deterioration in a patient's health. We saw physical health support plans in place to manage sudden deterioration in a patient's health. For example, an individual had a specific plan in place to manage daily focal seizures. This clearly set out information about the condition, and the actions to follow to prevent

seizures and in case a seizure occurred. This included giving medicines at the exact time each day, if a seizure lasted longer than five minutes giving specific medication and if the individual's blood oxygen saturation level dropped below 95% to give oxygen. Staff said this helped with their understanding and confidence in giving support when managing seizures.

Staff were able to talk through what they would do in an emergency. Staff said they had participated in emergency simulations such as a patient having a cardiac arrest.

Staff monitored physical health risks through frequent observation and physical health assessments. Staff on the ward met each day to discuss any changes to patients' risks and to assign risk management activities to each member of staff. Staff reviewed the effects of each patient's medicines on their physical health according to the National Institute for Health Care and Excellence (NICE) guidance on adverse reactions to drugs. Staff ensured each persons' physical health was monitored regularly. They made use of the National Early Warning Scores (NEWS2) to improve detection of and response to clinical deterioration. Any medicines or treatment procedures that required additional monitoring had these carried out within the required timeframe.

Each patient had a white board in their room and a noticeboard. These contained important information about their care needs such as the specific care and support they needed to mobilise. Each patient had a personal emergency evacuation plan, which was formulated on admission and kept in their folders.

Staff told us they had been trained to use equipment such as hoists. They were never expected to use equipment they had not been trained to use.

Use of restrictive interventions

The levels of restrictive interventions at the service were low. Staff were trained by an external company, in conflict management, physical intervention and risk reduction for patients of mental health services. Staff said they were trained in managing actual or potential aggression. Staff were knowledgeable on de-escalation techniques and strategies to support challenging and aggressive behaviour. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff implemented behaviour support plans when patients became consistently challenging or aggressive. We saw examples of positive behavioural support plans that clearly identified patient needs such as severe cognitive impairment leading to severe disorientation, confusion and challenging behaviour. Interventions included using open body language, letting the patient know they were safe, and distraction-based conversation. The noticeboard in the patients' rooms also contained personal information about the patient that the staff could use to speak to them about, as topics that interested them, as a de-escalation technique.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Whenever possible, de-escalation would avoid using a medicine.

Blanket restrictions were low at the service and were there for the patients' safety. There was a higher level of restrictions on Thames Unit due to the elevated risk of patients on that ward. This included keeping the kitchen and garden doors locked, and sharps, cigarettes and lighters were kept in the nurse's office. Patients could access these if they asked a staff member. The use of bedrails for a patient was individually risk assessed.

Requires Improvement

Services for people with acquired brain injury

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There were 9 safeguarding concerns reported at the service over the previous 12 months. This included 2 concerning medicines not being given to a patient.

Staff received training on how to recognise and report abuse for adults and children, appropriate for their role. Staff said they kept up to date with their safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies such as the local authority. Staff could give examples of safeguarding alerts they had made. The social worker was the safeguarding lead for the service. They attended quarterly safeguarding meetings with the local authority. Staff said the service's social worker communicated directly with safeguarding leads in the local authority about referrals and the progress of cases. Staff gave clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were confident in identifying and making safeguarding referrals and knew who to inform if they had concerns. Patients said they felt safe in the service and had not experienced or seen staff being mean or abusive to any patients. Patients reported they could raise any concerns confidentially in 1 to 1 meetings.

Safeguarding concerns were discussed at the clinical governance and team meetings, and any themes identified. Staff were aware of the providers whistleblowing processes.

Staff followed clear procedures to keep children visiting the ward safe. Children were able to visit the patients with adult supervision, and visits took place in communal areas.

Staff access to essential information

Staff were able access to clinical information and maintain high quality paper-based and electronic clinical records.

The service had been a victim of a cyber-attack on their care records system in summer of 2022. Immediately the service did not have access to the patient's care records. The service drafted templates to be used in the interim. Documentation such as handover notes and clinical reviews were being recorded electronically and added to the service electronic system and these were easily accessed. Most care plans were being updated electronically and printed to be placed in patients' records folders. The quality administrator undertook fortnightly checks on every patient's folder to ensure all documents were in place and up to date.

All information around patient risks were shared and recorded at handover, and the service kept a record in paper and electronic form.

Care plans were concise yet held enough detail. Care plans contained protocols describing how to care for the patient's individual risk, such as diabetes or seizures. Some care plans had an easy read version of the protocol kept in the patient's folder so that staff could easily identify how to care for the patients. Permanent and bank staff had their own computer logins to access the electronic system. Agency staff received temporary logins for their shift. Patients' paper records were kept in the nursing office which was locked.

Requires Improvement

Services for people with acquired brain injury

Medicines management

The service did not have effective medicines management systems. Medicine audits identified frequent medicine errors, and these were still occurring. Medicine audits were not always completed.

We reviewed 10 patient medicine administration records, and the medicine audits for both wards for the previous six months. When we asked the registered and ward managers about medicine errors, they provided us with information that showed the service had recorded over 360 medicines errors over the 6 month period prior to inspection. This information came from the audits completed by the external pharmacy commissioned by the service to supply medicines and make checks of practice. This included 229 incidents of medicines being out of stock, 114 recording omissions and 20 missing forms or routes of administration of medicines. 14 of these errors were recorded on the service incident reporting system.

The service had quarterly medication safety meetings to discuss the outcomes of the weekly audits completed by the external pharmacy company. In the meeting minutes for the medication safety meeting in April 2022 it was determined that an incident report would be completed for each instance there was a signature missing from a medication administration record. The issue with medicines being out of stock was identified at this meeting but there was no learning recorded and no actions were put in place. The minutes for the meeting in July 2022 identified that the high rate of medicines being out of stock on Heathside Unit was still a concern but again no action plan was put in place. This raised the risk of harm to a patient due to out of stock medicines and could have serious consequences to their health.

There was an incident in October 2022 where a patient was not administered their prescribed hypertension medicine for 7 days as it was out of stock. The patient's vital signs were checked, a safeguarding alert was raised, and the incident was reported to CQC. The patient was put at risk of avoidable harm by the absence of prescribed medicines in stock.

Actions following this incident included the registered manager implementing a medicine ordering process flowchart, which involved the service, GP surgery and pharmacy, to prevent medicines from being out of stock in the future. However, at the time of inspection this was a new process that had not been yet been embedded.

The August, September and October 2022 clinical governance meeting minutes showed these medicine errors were discussed in detail. However, the team meeting minutes from these months did not show this had been cascaded down and discussed so it was not clear the learning was being shared with all staff and embedded.

The registered manager told us the service was moving to an electronic medicine administration system and this would have an inbuilt process that would reduce the medicine errors. Staff had already been trained by the pharmacy provider and the service had ordered the electronic tablets which we were told by the registered manager would arrive in the next few months.

Until the service transferred to this new system the ward managers had introduced a peer review process following each medicine round to check that records had been completed and were accurate. The monthly medicine audits completed by the ward managers showed a reduction on Heathside Unit from 8 records with signatures missing in June 2022 to 3 records with signatures missing in October 2022. However, there was no record the audits for August and September 2022 for Heathside Unit had been completed so we could not see the number of errors for those months.

Staff monitored the fridge and room temperature where medicines were stored. Medicines and controlled drugs were stored and managed appropriately so that they would remain safe and effective for use. Information relating to medicines was accessible via password protected laptops. Any paperwork relating to medicines and equipment checks were stored in locked clinic rooms. Staff could access advice from the pharmacy's clinical pharmacist.

Track record on safety

The service had not reported any serious incidents. However, there had been more than 300 medicine errors in the 6 months prior to inspection. This included an incident in October 2022 where a patient had missed their medication for 7 consecutive days.

Reporting incidents and learning from when things go wrong

Staff recognised most incidents but not all medicines incidents were reported on the service's incident reporting system. When things went wrong, staff apologised to patients. Managers investigated incidents but it was not always clear how lessons learned were shared with the whole team. and this did not always result in improvements to the service, such as with medicine errors.

Staff told us they knew what incidents to report and how to report them. Staff understood the duty of candour. They said there were open and transparent and gave patients and families a full explanation if and when things went wrong. Patients told us that staff apologised when they made a mistake.

Staff said once an incident occurred this was recorded on the incident recording system and the patient records would be updated. Records showed that incidents and subsequent actions were being recorded, although not all medicines errors were recorded as incidents. Incidents were reviewed by the registered manager and consultants. If the incident was determined to be a serious incident this would be escalated to the provider, and a lead investigator assigned to investigate this.

Learning from incidents and complaints was discussed at morning handover meetings, in team meetings and in clinical governance meetings. Meeting minutes showed this. Staff could give examples of recent incidents and the learning from them. Staff said they were debriefed and received support after incidents. Staff also raised any relevant safeguarding concerns if needed.

The minutes from the clinical governance meetings showed that a monthly incident report was generated and shared. The top two themes for incidents in the service was patient falls and medicine errors. The service had started a project around patient falls prevention to reduce the number of incidents of this.

Medicine audits confirmed that there were frequent errors. The top two themes were medicine administration being missed due to medicines being out of stock, and medicines not being signed for. There was an incident in October 2022 where a patient was not administered their prescribed hypertension medicine for 7 days as it was out of stock. There was no harm caused to the patient, however there was a risk there might have been. This was reported and investigated by the service. A safeguarding concern was raised and the CQC was notified.

Meeting minutes from the April and July 2022 quarterly medicine safety meetings showed that although the issue of medicines being out of stock had been identified there was no learning from this or action plan in place prior to this incident in October 2022. Following this incident, the service then implemented a medicine ordering flowchart. However, this had not yet been embedded.

Requires Improvement

Services for people with acquired brain injury

Are Services for people with acquired brain injury effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. Easy read protocols were included in patients' folders so that staff could easily access this information.

We reviewed 8 patient care and treatment records. The consultant neuropsychiatrist assessed patients face to face prior to admission to clarify whether the patient was appropriate and could benefit from the treatment the service offered.

Care plans were personalised, holistic and recovery and goal orientated. Staff developed a comprehensive care plan for each patient on admission or soon after that met their mental and physical health needs and were updated when necessary. Each need identified had a separate care plan such as for physical health, nutrition and challenging behaviour. This meant that each patient had many care plans. The service had assessed that patients had too many care plans and some care plans overlapped in content. The service leads were undertaking a quality improvement project to reduce the overall number of care plans, and for each patient to have a standardised set of care plans covering all areas of identified need.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Following the assessment, an initial care plan was written stating the level of observation for the patient and listing further investigations that needed to be carried out, such as physiotherapy assessments. Falls risk assessments were also completed as part of the assessment process and updated after any subsequent falls.

Care plans explained what nursing staff and rehabilitation staff should do to support the patient to relearn and practice their skills. For example, one patient had a goal to be able to complete their personal care with minimal assistance. The care plan actions included ensuring the patient had appropriate attire and products for this.

Staff liaised with family members to build comprehensive care plans. For example, for one patient, staff asked their wife what activities the patient enjoyed before they experienced a stroke. The wife shared that the patient would want to be able to walk the dog again, so this was incorporated in their care plan as part of the mobility goal.

Staff assessed and managed the physical healthcare needs of patients. For example, staff supported a patient living with stroke and diabetes in accordance with a care plan which covered their diet, medicines and the monitoring of their weight and blood sugar levels. Patients said they were supported around their needs and their physical health was assessed when they were admitted. Patients felt comfortable in discussing physical health in clinical reviews and if needed bring up issues directly with staff.

Staff used both electronic records and paper records to record care planning for the patient. The same information was contained in both the electronic and paper records due to the loss of the care record system. Staff we spoke with knew where to find information, and knew the risks and care needs for each patient.

Some patients had needs in relation to their mobility, which were assessed by a physiotherapist on admission. The multidisciplinary staff team decided what type and the frequency of physical health checks each patient should have. For example, staff checked the weight and body mass index of some patients each week because there were concerns about them maintaining a healthy weight.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audits. There was an audit plan in place but records of 2 planned medicines audits could not be found.

Staff made sure patients had access to physical health care, including specialists as required. All patients were registered with a local general practitioner. The general practitioner attended the service weekly. Staff said patients with long-term health conditions in addition to their brain injury were referred to other secondary healthcare services when required. Staff supported patients to attend appointments at other hospitals in relation to their physical health. Patients said they were able to discuss any physical health concerns with staff.

The service provided care and treatment based on national guidance and evidence of its effectiveness. In accordance with the National Institute for Health and Care Excellence (NICE) guidance on rehabilitation after traumatic injury, the service's multidisciplinary team assessed patient's clinical needs and worked with them and their families and carers to develop rehabilitation goals. The service provided treatments to aid cognitive, physical and psychological rehabilitation.

Staff helped patients live healthier lives by giving advice. Staff said they supported patients to make the right food choices to ensure they maintained good health. Patients confirmed that staff talked to them about healthy eating and staying hydrated. A dietitian visited the service twice a week and provided advice on healthier food choices. The service had monthly catering meetings, which the dietitian attended.

Staff supported patients with their self-care and everyday living skills. One patients' goal was to complete their personal grooming with minimal assistance and staff supported them with this. Staff helped patients develop everyday living skills.

Staff had undertaken smoking cessation training and they encouraged patients to stop smoking. The service provided nicotine replacement therapy if the patient wanted it. However, if a patient wanted to smoke, they were able to use the garden. We were told this was to protect the patients due to the building's location on a busy main road. This was not in line with national guidance that states mental health services should be smoke free. At the time of inspection there was only one patient who smoked.

There was information on display in both wards on how to eat healthily, the importance of keeping hydrated and how to stop smoking.

The service used the UK rehabilitation outcomes collaborative and health of the nation outcome scales for acquired brain injury to report outcomes for the patients. The consultant neuropsychiatrist told us the outcomes from these were good with 84% of patients returning to their own homes. These outcomes were also used to show commissioners the cost/benefit of the service, and the outcomes showed the service reduced the patient's costs overall. Therapists

reported outcomes for patients using different measures such as the functional independence measure and functional assessment measure for patients who had had a stroke. This outcome measure had been introduced in September 2022 and was not yet fully embedded. The Berg balance score was used to objectively determine a patient's ability to safely balance during a series of predetermined tasks.

Therapists set clear measurable goals for patients, although two patients told us they were not aware of their own therapy goals.

Wards had activity workers who supported patients to participate in a range of games and activities. A tai chi group was available for patients and a music therapist provided sessions on Heathside Unit. Staff supported patients to return to study or work. One patient was supported to return to the job they had before admission within 3 months.

Staff had a schedule of audits to complete in order to monitor the quality of the service, although these did not always take place. For example, the service could not provide evidence to show that 2 monthly medicine audits for Heathside Unit had been completed. The service had a quality assurance framework to monitor the audits and identify areas for improvement. The service had a site improvement plan that managed the actions from these audits, as well as other areas identified for improvement. For example, the service had monthly mattress audits. The most recent was in October 2022 and showed that 2 mattresses on Thames Unit had failed compressions and would need to be replaced. This meant that the base of the bed could be felt when manually compressing the mattress. The site improvement plan showed this had been identified in the September 2022 audit and a request to the head of support services was made to replace these. This was followed up in October 2022.

Skilled staff to deliver care

The service had access to a range of specialists. However, the occupational therapist team had 6 vacancies out of 9 posts. The psychology team also had 1 clinical psychologist and 1 assistant psychologist vacancy. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills but not all appraisals were completed on time.

The staff team was led by a consultant neuropsychiatrist and included physiotherapists, speech and language therapists, clinical psychologists and a social worker as well as nursing staff. The therapies teams also included an occupational therapy team. However, the lead occupational therapist, 4 occupational therapists, and 1 rehabilitation technician roles were vacant. There was a rehabilitation technician and an activities co-ordinator in post. A permanent occupational therapist was to start working at the service in December 2022, and a locum occupational therapist that was currently working 2 days a week planned to work full time from December 2022. There was 1 vacancy for a clinical psychologist and 1 for an assistant psychologist. The service had successfully implemented a ‘grow you own nurse’ programme and was looking to implement this for therapists to address staffing vacancies. The ‘grow you own nurse’ programme was a pathway from rehabilitation assistant to registered nurse, where the provider provided paid part time study leave for the two-year nursing degree, followed up with placements in hospitals. There were three senior rehabilitation assistants on this programme at the service.

The therapies teams provided a monthly training session for staff, with a different discipline each month. There was no dedicated dysphagia training for the service. Dysphagia is the medical term for swallowing difficulties. The lead speech and language therapist for the service was in the process of creating training about this for staff to build their confidence in this area, and so they could assess whether patients’ meal preparation was appropriate for their individual needs.

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The service did not provide specialist training related to acquired brain injury. However, a practice development nurse was due to start working at the service in November 2022, and their role would include implementing this specialist training. Additionally, the head of nursing and quality was looking into specialist training for the nursing staff as part of their continual professional development. The service was planning to send a team of the staff to the world congress on brain injury in Ireland in 2023.

The medical staff were leading on a project to have more staff training around the conditions of the patients of the service. For example, there had been an increase in the service taking patients with Parkinson's disease. The consultant neuropsychiatrist had attended a national forum on Parkinson's disease, and had used this material to provide training on the neuropsychiatric complications of Parkinson's disease.

Staff, including bank staff, said they were given a full 2-week induction to the service before they started work. When staff joined the service, they received an introduction to the ward and spent time shadowing more experienced staff. Managers supported staff through constructive appraisals of their work. The appraisals for the nursing staff were up to date. However, appraisals for the therapy team were at 63%, and for non-clinical staff 54%

Staff said they received supervision and were able to discuss their wellbeing, case management, personal and professional development and to reflect on and learn from practice. They could approach their manager at any time. Staff received supervision every 6 weeks and supervisions for the service were up to date.

Team meetings were held monthly for each ward. Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff said they attended regular business and governance meetings.

A patient reported that when some staff tried to help him move, their technique was poor and it caused discomfort, whereas as other staff were more skilled and moving was easier. At the clinical governance meeting in October 2022 it was identified that new staff needed to have their competencies observed and completed. The practice development nurse role, who would complete these, was vacant at the time of inspection however there was someone starting in this role in November 2022 and they would take over this.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Multidisciplinary team members reported that they worked well together. Every week the consultant neuropsychiatrist would conduct a medical review of all of the patients, and then would meet the multidisciplinary team the next day to discuss patient care and treatment. Staff valued these meetings. Staff felt they supported learning across their teams. Staff said the multidisciplinary team worked very well together and valued each other's' input.

The consultant neuropsychiatrist had a good relationship with the hospitals in the greater London area that referred to the service. These hospitals were familiar with the admission criteria for this service, and this streamlined referrals.

This service was 1 of 3 providers of this type of service in the greater London area. The service was piloting a new network of referrals with the other 2 providers of this service. Previously there had been a lot of duplication in referrals. Now the 3 services met weekly, looked at all of the referrals together and divided them based on geography and clinical picture. The consultant neuropsychiatrist said this was a close collaboration that was working well.

Staff had effective working relationships with external teams in the organisation. Care records showed communications and updates on patient care with other teams such as home borough social workers and physical health NHS teams.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. However, at the time of inspection this was at 62%. The registered manager had identified this at the October 2022 clinical governance meeting so that ward managers could book their team to complete this training.

Staff told us about the steps they had taken to ensure patients were informed of their rights and were aware of the Independent Mental Health Act advocate. Patients said they were aware of the independent mental health advocacy service.

There were no detained patients on the ward at the time of inspection and the registered manager told us the service did not often have detained patients.

Good practice in applying the Mental Capacity Act

Staff had delayed making applications for a Deprivation of Liberty Safeguards (DoLS) for 2 patients. This meant these 2 patients were being unlawfully deprived of their liberty.

The Deprivation of Liberty Safeguards provide protection for patients who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements. When an existing DoLS authorisation is coming to an end the service must review whether it is still necessary. If having reviewed the patient's current situation, the service concludes that the authorisation needs to continue then a further authorisation should be requested. For the 2 patients with delayed applications, we found the DoLS for one patient had expired on 13 July 2022, a further application was not made until 25 October 2022. The registered manager told us that for this patient a further application had been, made on the 13 July 2022 but they were not able to locate the evidence of this. The DoLS authorisation for a second patient had expired on 29 August 2022, and a further application was made on the 3 November 2022 after we raised this during the inspection. The 2 patients had been detained without authorisation for several months.

The registered manager told us this was due to the social worker, who had sole oversight of this process, being on long term leave. The social worker had sole access to the spreadsheet used to oversee the DoLS processes, and other staff were not able to access this in their absence. The registered manager and the head of nursing and quality told us there was a service wide project to centralise the management of DoLS. The head of nursing and quality would have ownership of this process with reminders of when a further application would need to be made. The head of nursing and quality told us they planned to include Mental Capacity Act scenarios in team meetings to build staff knowledge and confidence around this. We were told the DoLS were in place to protect the patients, and they still had access to the community and fresh air.

Staff assessed patients' capacity to consent at admission, and staff supported patients to make decisions on their care for themselves. Staff knew how to access the Mental Capacity Act policy. Staff told us that they assumed that patients had capacity, and a capacity assessment would only be arranged after the initial assessment if evidence suggested that

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a patient's capacity was lacking. Mental capacity was reviewed and assessed at point of admission and recorded in the care records. Where a patient lacked the mental capacity to consent to treatment, the service completed referral documents for a DoLS authorisation to the relevant local authority. Staff received and kept up to date with training in the Mental Capacity Act, and most staff had a good understanding of the principles.

Staff supported patients to make decisions when they had the mental capacity to do so. Staff said the capacity of patients often usually improved whilst they were at the service, so staff said they often waited until they could decide for themselves. Staff said they would repeat information often because patients had memory problems. Patients told us that staff explained their care and treatment in terms that they could understand. Care records showed that the staff followed the best interest processes if patients lacked capacity to consent. Staff liaised with the patient's family and other agencies as appropriate to ensure that the patients' best interests were fully considered.

At the time of the inspection, 13 patients were subject to authorised DoLS.

Are Services for people with acquired brain injury caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We observed kind and respectful interactions between staff and patients. Patients appeared at ease with staff. Staff spoke compassionately about patients. Staff were discreet, respectful, and responsive when caring for patients. Staff responded promptly to requests from patients such as fetching something from their bedroom that they had forgotten.

We observed staff encouraging patients to support their peers by sharing their own stories and progress with recovery and rehabilitation.

Patients said staff treated them well and behaved kindly, and they had never seen staff behaving unkindly towards people. Patients said they were happy with the care they received and felt that they got enough support. Patients said staff were polite, respectful, non-judgemental and caring, and provided care that met their individual needs. Patients also reported staff provided help, emotional support and advice when they needed it, alongside their physical rehabilitation. Patients said staff were responsive to their needs. They said staff were visible and they could access a doctor and the consultant in a timely way. Staff we spoke with were motivated to offer care that promoted people's recovery. Staff had a good understanding of the patients they cared for and could talk about their rehabilitation needs, their interests and likes and dislikes.

Staff felt comfortable and supported by their colleagues to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

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Services for people with acquired brain injury

Patients felt staff were suitably discrete when communicating and respected their privacy and dignity. Staff were fully aware to knock first before entering patients' rooms, signs were up stating that staff should knock before entering, and patients confirmed staff knocked and called out before entering rooms.

Involvement in care

Staff mostly involved patients in their care planning and ensured that patients had easy access to independent advocates. The advocate provided a monthly report from their meetings with patients which the service used to make improvements. Managers asked patients for informal feedback regularly.

Involvement of patients

Staff introduced patients to the service as part of their admission. Staff said they involved patients in planning their care and rehabilitation, although 2 patients felt they had not been involved. Staff provided patients with a copy of their therapy timetable every week. Some patients told us that staff took the time to explain the rehabilitation process to them and they understood the reasons for their therapy sessions and how practising their skills would assist recovery. Some patients said staff discussed their needs, care planning and risk assessments with them in 1 to 1 sessions. Most patients reported they received clear information from and explanations of their care and the treatment from staff.

Most patients said they felt involved in their recovery planning. However, 1 patient we spoke with said they were not aware they had a care plan and had not been given a copy of one. Another patient said they had a care plan for a specific activity they carried out every week, but that was all. Two patients said they had not been involved in setting goals for their recovery.

Patients led a social committee for the service which met every 6 weeks. Patients had a fund for this committee, and they were able to decide how to spend this money. For example, the patients wanted a PlayStation for the service, so they agreed at their committee meeting and this was signed off by the patients. The patients had a barbeque in the summer. However, the service had not yet reinstated the patient community meetings, which had been stopped at the start of the pandemic, although there were plans to do this.

An independent advocate came to the ward every week. They spoke with patients and raised any concerns with managers at the service. Patients knew the name of the advocate. Information on how to contact the advocate was on display. The advocate provided a monthly report to the registered manager who then used this to make improvements to service. For example, patients had asked for a step in the garden to be repaired and this was completed. Patients also asked for the hydro pool to be repaired and the registered manager told the patients this had not been possible due to the difficulty in obtaining the necessary parts. The registered manager was planning to have someone with lived experience take the role of advocate, as they would better understand the needs of the patients.

The registered manager told us that they, along with the ward managers, would do a quality walk around the service to ask patients for informal feedback about their care and the therapies they were receiving. Staff confirmed that patients were asked for feedback about their stay at the hospital when they were discharged. However, clinical governance and team meeting minutes showed that only patient feedback from the weekly advocacy meetings was shared with the service and staff.

Some patients told us they felt confident to give feedback on the service and their treatment in clinical review meetings and directly to staff.

Requires Improvement

Services for people with acquired brain injury

Involvement of families and carers

Staff informed and involved families and carers in the care of the patients. However, there was no formal process to collect feedback from families and carers.

Families and carers were involved in the patients' care from when a referral was made. Patients' records showed staff communicated and updated the family's members regularly. Families and carers were invited to the initial assessment that took place in the hospital from where the patients were referred. The lead speech and language therapist used the cognitive communication checklist for acquired brain injury with families and carers to identify and assess functional difficulties. They had also created an informal questionnaire for families and carers called 'patient from the perspective of a loved one' so that families and carers could provide a personal, holistic representation of the patient. They were also invited to attend care planning meetings and discharge meetings. Staff told us families and carers were important to the patient's discharge as they would continue to support the patient at home.

We observed a clinical review meeting where the multidisciplinary team explained each aspect of care to the patient and their family. The family were able to feedback and input into the review process and care planning. The family felt this was an extremely supportive process.

We spoke to 13 families and carers. Ten families and carers told us the patients felt safe and were well cared for, and 6 families and carers said they were kept informed of their patient's care. However, one carer said they not been invited to attend any meetings. Two carers said they did not know the patient's care plans.

Most family members and carers told us they were able to contact staff when they needed to, but 4 families and carers told us that the service was difficult to contact at times and that the communication could improve. Visiting times were between 10 - 5pm each day. We saw relatives were able to spend time with their loved one.

The service had formerly run a face to face carers forum, but this was stopped as the families and carers came from across a large area and there was poor attendance at meetings. The service provided a QR code at the service that families and carers could use to access a feedback form. However, clinical governance meeting minutes from August, September and October 2022 showed the service was aware this was not being used.

Are Services for people with acquired brain injury responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient access and discharge well. They worked with services that managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

The service had clear inclusion and exclusion criteria. The service did not take patients that had a spinal cord injury, a tracheostomy, nasogastric intubation or needed regular blood transfusions. Staff said that where it became clear that patients were not suitable the team worked to move them to a more suitable setting quickly. For example, staff were able to discuss a number of cases where patients' behaviour was too challenging for the service to manage and the service worked closely with NHS England and other providers to ensure patients were appropriately transferred.

Requires Improvement

Services for people with acquired brain injury

The service had an effective referrals system. The consultant neuropsychiatrist had a weekly meeting with NHS England to plan admission and discharges. They also had weekly meetings with the other 2 providers of this type of service to manage all referrals to these services. The service had a weekly meeting where the consultant neuropsychiatrist would consider all new referrals and whether they were appropriate for the service.

Patients were funded for a maximum 6 month stay at the service. If the patient needed to stay longer the consultant neuropsychiatrist would make an application to NHS England. The average stay for patients at the time of inspection was 6 months,

Discharge and transfers of care

Discharge planning was considered from the admission. The service worked with the clinical commissioning groups to find suitable accommodation for patients after discharge. The registered manager and ward managers monitored the number of patients whose discharge was delayed. Most patients returned to their own home. Patients were aware of roughly how long they would be staying in the service. Some patients knew they would be returning home once their support at the service was complete. Two patients told us they were unaware of when they were likely to be discharged and what the plan was. They said they were not kept informed. Both had been in hospital for several months and said they had set their own target date for discharge.

At the time of inspection there were 4 patients with a delayed discharge. The reason for the delayed discharges was difficulty in finding appropriate accommodation in the community.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could have hot drinks and snacks at any time. However, the patients had mixed views about the food.

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom, which they could personalise. Some bedrooms had an ensuite bathroom. Some patients preferred to have their clothes laundered by their families. They were provided with laundry baskets to use. The service had quiet areas and rooms where patients could meet with visitors in private or they could meet in their bedrooms. Patients had their own phones or could be helped to use an office phone.

The layout of the service was suitable for patients with acquired brain injuries. The service was wheelchair accessible. A range of rehabilitation equipment and hoists were available to support patient care and treatment. There was a therapy room on each ward and gym rooms with exercise equipment. Both wards had an outside space that patients could access easily under the supervision of staff. Patients said premises were suitable and provided privacy and confidentiality.

The wards had occupational therapy kitchens to assess patients' abilities to cater for themselves. Staff could adjust the height of the countertops to accommodate a wheelchair.

Patients, who were able, could make their own hot drinks. Patients had snacks in their rooms and fruit and other snacks were available in dining rooms. Patients were supported by staff to have drinks and snacks.

The service offered a choice of meals for patients and catered to individual preferences and needs. Patients were able to select their meals daily from a range of options. Vegan and vegetarian options were available. Meals were provided in line with patients' religious needs. Staff discussed the dietary needs of each patient at handover, including special diets, preferences and requests. Staff were also made aware of patients with poor swallowing who needed their meals presented in a particular way.

Patients could prepare their own breakfasts such as toast and cereal. Patients' own foods were labelled and kept in the fridges provided.

Patients had different views about the quality of food provided. While one person said the meals were 'ok' others told us that the food was of poor quality, lacked nutritional value and seasoning. One person said it was 'too hot'. A patient shared photographs with us of meals that had been provided, including a chicken meal, which appeared burnt. Occasionally patients received meals they did not order.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work and family relationships.

Staff helped patients to stay in contact with families and carers. Patients said staff supported them in maintaining contact with family members. Patients said staff encouraged them to maintain relationships both in the service and the wider community. Patients said they were often supported to visit family members, go on leave to see their family, and had family members visit the service.

Staff supported patients who were studying or to return to work. One patient came to service with Guillain-Barre syndrome which is a condition that affects the nerves and causes problems such as numbness, weakness and pain in the limbs. This patient was supported to and able to return to work within three months of admission.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff had training in equality and diversity. Staff were aware of some of the equality and diversity issues patients might face, such as discrimination and a difference in the quality of care and support relating to protected characteristics.

The registered manager told us that if patients identified as part of the LGBTQ+ community the service could provide them with phone numbers for support services.

Staff could provide care plans and other information in an easy read format for patients. The speech and language therapists (SALT) advised staff on how to communicate with patients and wrote information on this into care plans. The SALT had created a number of communication boards to assist patients to communicate their needs.

The accessible information standard (AIS) applies to people using services who have information or communication needs relating to a disability, impairment or sensory loss. However, when we asked them, not all staff were able to explain the accessible information standard and its 5 requirements. However, care plans we reviewed showed evidence that patients' accessible information needs had been assessed and patients were given information in a way they could understand.

Requires Improvement

Services for people with acquired brain injury

The service supported and adjusted for disabled people and those with communication needs or other specific needs. The service was wheelchair accessible.

Staff made sure patients could access information on treatment, local services, and how to complain. Patients could obtain information leaflets available in a range of other languages spoken locally. Managers made sure staff and patients could get help from interpreters or British Sign Language interpreters when needed.

An independent advocate came to the ward every week. They spoke with patients and raised any concerns with managers at the service.

Patients had access to spiritual, religious and cultural support. Staff could request this for patients if needed. For example, the service had a lot of patients from the African Caribbean community and the activity co-ordinator would support them to attend church.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Information on how to make a complaint was available on both wards, including in an easy read version.

Staff were aware of the complaints policy and provided patients with information on how to complain. Staff understood the policy on complaints and knew how to handle them. Most patients, families and carers said they would raise any concerns they had with the ward manager. However, 1 patient said they did not know who to complain to.

The service received 7 complaints in the 12 months prior to inspection. These included 3 complaints about the attitude of staff, 1 regarding bland food, 1 that the site would not allow a microwave in the patient's rooms, 1 regarding sharing of information between family members and 1 where a patient wanted a full day of therapy. The registered manager investigated all complaints and tried to resolve complaints informally first. Staff said that learning from complaints was shared through team meetings, supervision, 1 to 1 sessions and discussed within the multidisciplinary teams.

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

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The leadership team had the required skills, knowledge and experience in the rehabilitation and care of patients with acquired brain injury. The leadership team included the hospital director who was also the registered manager, the consultant neuropsychiatrist, the head of nursing and quality, and the ward managers. The hospital director had been the CQC registered manager of the service since December 2021. The head of nursing and quality was newly appointed and had been in the role for two months at the time of inspection. There was a vacancy for the head of therapies, and a practice development nurse was starting in November 2022.

Requires Improvement

Services for people with acquired brain injury

Staff spoke highly of the senior leaders and mangers in the service. Staff described a supportive team and supportive managers. The two ward managers were described as very supportive and very hands-on. They were very visible on the ward and always ready to help staff when needed. Patients, families and carers said they could speak to the leadership team about any concerns or feedback they had.

The consultant neuropsychiatrist of the service had a good working relationship with the hospitals that referred patients to the service. As a result, the hospitals were able to streamline their referrals as they were aware of whether a patient would be suitable for the service.

The consultant neuropsychiatrist also worked closely with the consultants from the 2 services that provided a similar service and met regularly with them to discuss patient referrals.

Vision and strategy

Staff demonstrated the provider's vision and values and how they were applied to the work of their team.

Most staff were enthusiastic about the service and the work they did. Staff displayed the provider's values. The ward philosophy was on display in both wards.

The registered manager and consultant neuropsychiatrist told us that 84% of patients returned to their own homes after treatment at the service.

We observed that the staff were kind and caring with the patients. Patients told us that staff were very lovely to them and they feel they have improved at the service.

However, the values of the previous provider were on display in one ward and had not been updated.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear.

All staff we spoke to said the teamworking within the service was very strong and felt this was a vital aspect of the service. Staff felt positive and proud about working for the provider and their team. Career development was supported. Staff supervision included conversations about career development. Staff said managers supported them in identifying professional development opportunities. Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable in raising any concerns with their colleagues and managers. They felt their views and options would be listened to. Staff knew how to use the whistle-blowing process.

Staff said they felt able to speak up about any concerns they had about the care provided to people. The wards displayed information for staff on how to contact the provider's freedom to speak up guardian.

The provider had an employee assistance programme and a wellbeing scheme called ActiveCare rewards. The provider had increased the annual leave allowance as an incentive for potential employees. The provider held a wellbeing Wednesday for staff, with the senior management team attending, where they would provide breakfast for the staff.

The service had an equality, diversity and inclusion forum every 2 months that was chaired by the lead physiotherapist for the service. The forum discussed events and initiatives to promote equality and diversity at the service.

Requires Improvement

Services for people with acquired brain injury

Governance

Our findings from the other key questions demonstrated governance processes did not always operate effectively. Although incidents were mostly identified, improvement plans were not always promptly put in place, or were not monitored to make sure they were effective. There were no formal processes in place to obtain feedback on the service from patients, carers or staff, which meant key perspectives were overlooked. A lack of oversight of deprivation of liberty safeguards (DoLS) applications lead to significant delays and 2 patients being detained for some months without formal authorisation.

The systems in place to ensure learning from incidents and monitor performance of the service were not always effective. The leadership team attended monthly clinical governance meetings to oversee the quality of the service. Information from this meeting, which included learning from incidents, staff and patient issues, and compliments and complaints, was discussed at ward team meetings to share with all of the staff. However, this did not always lead to improvements, as medicine errors continued to occur despite being identified. Some audits had not taken place as planned.

The service had identified that medicines were frequently out of stock as early as April 2022. An action plan to address this was not put in place until an incident in October 2022 where a patient missed their medicine for 7 days. However, minutes from monthly clinical governance and team meetings showed that learning from other incidents otherwise took place.

The service had a quality assurance framework in place to monitor audits at the service, and a site improvement plan to manage the actions from these audits. However, these did not include the issues we had identified such as the medicine management concerns, lack of formal feedback process or the delayed DoLS applications.

The social worker was responsible for deprivation of liberty safeguard applications and authorisations. However, when they were off sick there was no oversight of this work area. This had resulted in 2 patients being unlawfully detained for some months and delays in applications.

The service did not have formal processes for gathering feedback from patients, carers or staff. Without obtaining these perspectives on patient, carer and staff experience the service was limited in evaluating and making improvements that mattered to people using or employed at the service.

Management of risk, issues and performance

There were systems in place to manage risk and issues to the service. However, the risk register did not reflect service issues we identified during the inspection.

The provider had a risk register in place. The registered manager identified from the risk register that the biggest risk was the recruitment of therapy staff. Other risks were limited parking at the service for staff due to the construction work happening next to the service. This meant staff had limited accessibility to the service if they drove to work. There was a plan to repaint the lines in the car park and use stickers if a car was incorrectly parked.

The registered manager also identified challenging behaviour from the patients to staff as a risk at the service. The staff were trained in de-escalation techniques and managers at the service supported staff following an incident. They would do a formal debrief with staff and ensure the staff members wellbeing.

However, the risk register did not include the issues we had identified such as the medicines errors, lack of formal feedback processes for patients, carers and staff or the delayed DoLS applications.

Requires Improvement

Services for people with acquired brain injury

Information management

Teams had access to the information they needed to provide safe and effective care.

Patient care records were recorded on both electronic and paper records due to the electronic records outage. The service had implemented an interim process to manage care records until the care records system could be reinstated. The interim process was effective, and the staff continued to manage good quality patient care records.

The service notified the Care Quality Commission of notifiable incidents

The managers had access to information to support them with their management roles.

Engagement

Although the service engaged informally with patients and carers to plan appropriate care and treatment, the service did not have formal processes to collect feedback from patients, families and carers for the purposes of evaluation and making improvements to the service. The service had not implemented a staff satisfaction survey for some time and did not formally gather anonymised feedback from the staff on the quality and safety of care.

The service did not have a formal process for obtaining feedback about the service from patients, carers, families or staff. There was no assurance that all patients, carers and families had been asked for their feedback, or that any feedback gathered was being used in a meaningful way. Clinical governance and team meeting minutes showed that only patient feedback from the weekly advocacy meetings was shared with the service and staff.

The service used staff satisfaction surveys to learn from staff perspectives, to fully evaluate the service and make improvements. The most recent survey had been completed in November 2021. The lowest scores were around staff feeling they were not paid fairly, and that the service did not offer special and unique benefit to staff. The service developed an action plan to address the results of the survey. This included restarting face to face sessions with staff, arrange a meeting to identify issues with computers, and to support more developmental opportunities for staff. The survey for 2022 had been delayed as the service had changed their methodology, and this took place in January 2023.

Learning, continuous improvement and innovation

The service engaged in quality improvement projects to improve the service.

The service had a strategy called ‘grow your own nurse’ and were looking to implement this for therapists. The provider supported staff to continue studying. For example, there was a registered nurse at the service that was being supported to complete their master’s degree.

The service had many quality improvements projects. Since the last inspection the service had implemented a care plan improvement project to reduce the number of care plans while still ensuring care plans were of high quality. There was a quality improvement project to improve the options for weekend activities for the patients. Another example was that during the pandemic all qualified therapists at the service went on a three-day training course to administer medicines if the nurses had all been unavailable.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have effective medicines management systems. Medicine audits identified frequent medicine errors, and these were still occurring. Medicine audits were not always completed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have a formal process to collect feedback from patients, families and carers about the quality and safety of the service for the purposes of evaluation and improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective system in place to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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Requirement notices

The service did not ensure that learning from incidents is shared and embedded effectively to prevent reoccurrence.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not always discharge their responsibilities under the Mental Capacity Act 2005 in a timely way. Staff had delayed making applications for a Deprivation of Liberty Safeguards (DoLS) for patients.