Care Quality Commission

Royal Hospital for Neuro-Disability

Royal Hospital for Neuro-Disability

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept detailed records of their assessments. They managed medicines well. Staff collected safety information and used it to improve the service. Managers investigated incidents. There was a system to share lessons learned with the teams on the ward and the wider service.
- The service had produced a safeguarding policy aligned to NHS England's Safeguarding Assurance Accountability Framework. Staff received training specific for their role on how to recognise and report abuse. All staff, both clinical and non-clinical were trained to the right level of safeguarding competency for both children and adults, this training was all in date and in accordance with their role.
- The service had achieved all of the seven standards of NHS England's Safeguarding Accountability & Assurance Framework (SAAF).
- The service had staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- Staff understood how to manage infection prevention and control and all areas were visibly clean. Staff wore appropriate personal protective equipment (PPE), including gloves and aprons to keep themselves and others safe from cross infection.
- There were systems in place for infection prevention and control. All staff and patients adhered to personal protective equipment (PPE) guidelines. There were clear isolation and separation areas to manage the care for patients, due to COVID-19.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and easily available to all staff providing care. Patient records were managed securely.
- Leaders had improved safeguarding processes and operated effective safeguarding processes throughout the service and liaised with local authorities for safeguarding monitoring. Staff at all levels were clear about their roles and accountabilities about safeguarding and had regular opportunities to meet, discuss and learn from the performance of the service.
- Governance processes had improved with clearer accountability and more multidisciplinary work. The service had improved the way they shared learning with staff. Information on how to leave feedback was clearly displayed in all service areas. Most staff were positive about their work, relationships with colleagues, support from managers and development opportunities.
- The leadership for patient safety and safeguarding was clear and was a thread throughout the service. Patient safety incidents and safeguarding were discussed and reported to the senior leadership team on a weekly basis. All incidents were reported on each ward along with action being taken.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Good 	Medical care which involves long term conditions was the main activity of the hospital. The hospital provides neurological services to the entire adult population of England. The services specialises in the care and management of adults with a wide range of neurological problems, including those with highly dependent and complex care needs, people in a minimally aware state, people with challenging behaviour, and people needing invasive and non-invasive mechanical ventilation. We rated the service as good overall because safe and well-led were inspected on this inspection and rated as good. There were ratings of good for effective, caring and responsive at the previous inspection.

Summary of findings

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Summary of this inspection

Background to Royal Hospital for Neuro-Disability

The Royal Hospital for Neuro-Disability (RHN) is an independent medical charity which provides neurological services to the entire adult population of England. The hospital specialises in the care and management of adults with a wide range of neurological problems, including those with highly dependent and complex care needs, people in a minimally aware state, people with challenging behaviour, and people needing invasive and non-invasive mechanical ventilation.

The RHN is registered to provide diagnostic and screening activities, treatment of disease, disorder or injury, accommodation for people needing nursing or personal care and transport, triage and medical advice provided remotely.

At our last comprehensive inspection in February 2020, the service was rated requires improvement overall. Safe and well-led domains were rated as requires improvement, and effective, caring and responsive domains were rated as Good.

The RHN has a total of 237 beds across 12 wards, which are arranged into five service lines; a brain injury service, continuing care, and specialist respiratory services, specialist behavioural service and young adult service. The hospital provides specialist care to patients with a wide range of severe brain injuries, a range of complex neurological disabilities caused by damage to the brain or other parts of the nervous system as a result of brain haemorrhage, traffic accidents or progressive neurological conditions. The hospital cares for patients who are highly dependent and have complex care needs, people in a minimally aware state, people with complex behavioural needs, and people needing invasive and non-invasive mechanical ventilation.

What people who use the service say

We used the Talking Mats Communication tool to capture what people who use the service said about the service. Talking Mats communication tool is based on extensive research and designed by Speech and Language Therapists. It uses unique, specially designed picture communication symbols, that are attractive to all ages and communication abilities and is used by clinical practitioners, carers and support workers in a wide range of health, social work, residential and education settings.

We spoke with eight patients during the inspection using the Talking Mats communication symbols. They told us they were very happy with the service they received. Examples of the comments we reviewed during the inspection included: “Very helpful and brilliant staff”, “Very friendly staff”, and “Staff always made me feel happy”, “Really good thorough care and treatment received, “very friendly service” and “very professional staff”.

How we carried out this inspection

We inspected this service using our focussed inspection methodology.

We carried out an unannounced focused onsite inspection on 8 September 2021. We complimented the onsite inspection with remote off-site interviews from 9 – 16 September 2021.

Summary of this inspection

The purpose of this inspection was to check what improvements had been made to the service since our previous inspection in February 2020, when we had rated the safe and well-led as requires improvement. Our plan was to re-rate the safe and well-led domains, by following all the key lines of enquiries in those domains. We used the long term conditions inspection methodology framework for the inspection.

The team that inspected the service comprised of a head of hospital inspection, an inspection manager, two inspectors, a specialist advisor and a national professional advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

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

We spoke with 15 members of staff including managers, matrons, medical director and nurses. We also spoke with 12 patients and reviewed five patient's records.

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.

Outstanding practice

We found the following outstanding practice:

- The service used the Putney Board as an improvement project for sharing learning, driving improvement and celebrating success. There was one on every ward. The Putney Board is a model where a ten-minute huddle takes place, which covered shared learning, ideas and issues, and celebrations of successes. These took place on every ward and the huddles were timetabled. All staff members were given the opportunity to lead a huddle and the executive level buddy for each ward was invited to attend. Feedback and ideas from the Putney Board huddle were shared with the service's matron and executive management team buddy, so that support could be given to each area to achieve their objectives, where indicated.
- The services had a Digital Application (App) which was a real time digital reporting of audit reports of the services. This had led to an improved oversight, risk mitigation and responsiveness across all levels of the organisation. We were told that digital ward audits for hand hygiene and decontamination of equipment were key components of the organisation's response to COVID-19.
- The safeguarding policy was aligned to that of the local CCG. The service had achieved all of the seven standards of NHS England's Safeguarding Accountability & Assurance Framework (SAAF)
- The service had produced a safeguarding policy aligned to NHS England's Safeguarding Assurance Accountability Framework. There was a weekly Serious Incidents, Complaints and Safeguarding meeting, led by the head of patient safety and quality assurance, where staff were updated on ongoing serious incident investigations, as well as new and ongoing safeguarding cases. All staff were able to attend these meetings and there were always senior nurses, a director, medical staff and pharmacists attending these meetings.
- There had been a specific project aimed at working with approximately 300 Health Care Assistants (HCAs), to focus on identifying safeguarding concerns and to move into a preventative phase of safeguarding. This work had been influential in helping HCAs understand the themes emerging from how care is delivered, their significant role in identifying where things might go wrong as they work closely with patients.

Summary of this inspection

- There was a Safeguarding Operation Assurance Group, led by the Head of Safeguarding, where issues of the month, all open safeguarding cases and referrals to the local authority were discussed. The local authority attended the meetings.
- The service had a safeguarding charter which had ten values, it was developed with involvement of patients and relatives. It had been shared with other organisations locally as an exemplar of good safeguarding practice.

Areas for improvement

Action the service SHOULD take to improve:

- There was no patient experience strategy in place; therefore, the provider should develop a Patient Experience Strategy.
- The provider should review their policies and term of references (TOR), so that they were all updated and in date.
- The provider should finalise their review of the Board Assurance Framework (BAF), so that it is updated and approved by the board.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (Including older people's care)

Safe	Good
Well-led	Good

Are Medical care (Including older people's care) safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw electronic training records were used to monitor mandatory training for each member of staff. These were managed effectively and identified key training modules, completion dates and outstanding training for each person in the team.

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff, and all staff had completed the mandatory training. Training modules included health and safety, general data protection regulation, fire safety awareness, infection prevention and control, COVID-19, manual handling, mental capacity act, duty of candour, and basic life support training. All clinical staff undertook annual mealtime refresher training, where indicated on their training profile.

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.

The service had produced a safeguarding policy aligned to NHS England's Safeguarding Assurance Accountability Framework. The Strategic Head of Safeguarding had external supervision from a national safeguarding system leader. This leader was also a member of the Safeguarding Adults National Network, which had over 500 members from the safeguarding community across health, social care and providers.

Staff received training specific for their role on how to recognise and report abuse. All staff, both clinical and non-clinical were trained to the right level of safeguarding competency for both children and adults, this training was all in date and in accordance with their role. All staff we spoke with had training on how to recognise and report abuse and they knew how to apply it. The overall safeguarding training compliance rate for staff over all three training levels was 98%. Staff told us they received regular training updates in adult safeguarding and safeguarding children and training was delivered to all new staff at their induction as a mandatory subject.

Staff we spoke with were clear about how they would identify patients they felt were at risk of abuse. A range of staff from different grades and disciplines were able to clearly describe what were the signs of suspected abuse that would worry them.

Good

Medical care (Including older people's care)

In the most recent performance report provided by the hospital as of March 2021, the uptake of safeguarding training compliance was 98% against the hospital target of 95%. Staff told us safeguarding training accessibility and support was very good within the service. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering from significant harm and worked with other agencies to protect them. All staff we spoke with were able to tell us signs that would cause them to be concerned about a patient and would lead them to raise a safeguarding referral. Staff knew how to make a safeguarding referral, if one was needed, and who to inform if they had concerns. All staff we spoke with knew who their safeguarding lead was. We were shown a safeguarding referral algorithm displayed on the notice board to remind staff how to make safeguarding referrals if one was needed.

There was a weekly Serious Incidents, Complaints and Safeguarding meeting, led by the Head of Patient Safety & Quality Assurance, where staff were updated on ongoing serious incident investigations, as well as new and ongoing safeguarding cases. Staff were also informed of new and ongoing formal complaints and informal concerns, as well as any compliments received. Potential serious incidents 24-hour reports were presented and discussed at this meeting in order to agree or disagree for reporting externally as a serious incident. All staff were able to attend these meetings and there were always senior nurses, a director, medical staff and pharmacist attending these meetings. Papers from the meetings were made available to all staff. The service provided staff with weekly safeguarding supervision in addition to attending internal safeguarding review meetings, local authority safeguarding referral meetings with lessons learnt shared with all staff in an open and transparent manner. A Safeguarding Champions network was in place and all ward staff had a champion who was supported by the strategic Head of Safeguarding, who had a visible presence within the hospital, through regular meetings with staff. Staff we spoke with said safeguarding team were very supportive and approachable with any anxieties staff might raise. A safeguarding lens was applied to patient safety incidents and assessment of both risk and abuse or neglect and discussed and reported on a weekly basis.

Input of operational safeguarding expertise in the form of a social worker was an important element of the safeguarding structure and complements the strategic work being undertaken. There had been a specific quality improvement project, led by the Head of Patient Safety & Quality, aimed at working with approximately 300 Health Care Assistants (HCAs) which focussed on identifying safeguarding concerns and to move into a preventative phase of safeguarding. This work had been influential in helping HCAs understand the themes emerging from how care was delivered, their significant role in identifying where things might go wrong as they worked closely with patients. All staff had been trained on how to report a patient safety incident and those who may investigate incidents have undergone specific incident investigatory training.

There was a Safeguarding Operation Assurance group, led by the Head of Safeguarding, where issues of the month were discussed as well as all open cases and referrals to the local authority, who attended the meetings. The service had a safeguarding charter which had ten values, it was developed with involvement of patients and relatives. It had been shared with other organisations locally as an exemplar of good practice.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Good

Medical care (Including older people's care)

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning services were provided by in-house staff. We saw a cleaning rota on the wall that specified what needed to be cleaned, and how often. This was signed to demonstrate cleaning had been completed. Ward managers told us they were able to access further cleaning if it was needed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw "I am clean" stickers on equipment to demonstrate to the next user that it had been cleaned. We also observed staff cleaning everything a patient had used, after they had finished using it, such as wheelchairs.

Staff followed infection control principles of personal protective equipment (PPE), including the use of gloves, aprons, face masks and visors where required. All staff who had contact with patients were observed to follow bare below the elbow principles and were always wearing the right PPE. Staff also followed infection prevention and control (IPC) principles when speaking with each other.

The service carried out monthly infection control audits to ensure all IPC principles were being followed. We saw the results for the most recent audit (August 2021) carried out and the service was following all their own guidelines and were 100% compliant in all the wards and records reviewed.

Managers told us that during the COVID-19 pandemic, they had followed NHS infection prevention guidelines and Covid 19 protocols and made it appropriate for their environment and patients. We saw their specific COVID-19 policies and they were in line with current government guidelines and had been regularly reviewed and amended throughout the past year. There were specific guidelines written for PPE, the patient pathway amendments, how to treat patients who had tested positive for COVID-19 and when to isolate and test them.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

We saw that inpatient and clinical facilities were designed in keeping with the Department of Health guidance in HBN 04-01 (Adult in-patient facilities: planning and design). Throughout our visit, we found the wards to be clean, well maintained and well-lit with appropriate equipment.

Resuscitation equipment was available on all the wards we visited, and tamper seals were in place. Emergency drugs were available and within the use-by date. Nursing staff carried out daily and weekly checks to demonstrate that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items. When checks were missed, senior staff followed this up directly with the staff involved.

Staff disposed of clinical waste safely. All bins were colour coded and labelled to ensure the right waste was put in the right bin. We observed bins were used correctly. We also saw sharps bins were correctly put together and labelled with the date they were started.

Electrical safety checks, including portable appliance testing and servicing and calibration testing, complied with current regulations and were all up to date. Servicing and calibration were completed via a service level agreement with an external company.

Good

Medical care (Including older people's care)

The service had enough suitable equipment to help them safely care for patients. Stock and storage of equipment, including disposable instruments, were well-managed and recorded. Equipment was stored in appropriate areas and specialised equipment was stored in locked cupboards, only accessible by authorised staff. We saw that fridge temperatures were recorded daily by staff.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient electronically, but also in paper form and stored them at the patient's bedside. We were told risk assessments needed to be completed within 12 hours of the patient's admission and this included, bed safety, falls, moving and handling, gastrostomy, catheter and behaviour.

On Drapers Ward, patients referred were discussed at weekly referrals meeting. Referred patients received an initial assessment by a doctor and a nurse. A doctor, screened referrals either in person or over the phone. Following the medical screening assessment, patients received a multidisciplinary (MDT) assessment before being placed on the 'active' (ready for admission), or the 'inactive' (not ready for admission) list.

General observations were carried out on admission and following the two-week isolation period, an electrocardiogram (ECG) and chest x-ray were carried out. Patients were also started on a food and fluid chart. We were told that any abnormalities or concerns with patient tests and observations, were escalated to the medical team.

National Early Warning Score 2 (NEWS2), was completed twice per day for each patient and when necessary for deteriorating patients. Staff informed the Clinical Response Service (CRS) of patients with NEWS2 scores of 5 and above. The CRS may visit the patient, based on their assessment. Elevated NEWS2 scores were re-checked within an hour and escalated accordingly. Medical staff were informed of the patient's condition by the CRS.

Intentional rounding was done two-hourly during the day and hourly during the night. We saw that some NEWS2 observations were completed during the night, when there was a clinical need. The ward manager told us they were not certain whether the time of the record was the time of doing the NEWS2, or the time it was recorded.

The RHN compiled a quarterly audit of safeguarding decision making and timely reporting, which was peer reviewed by the local Designated Safeguarding Adults Professional and the LA. The last two audits have been 100% in agreement with the RHN's decision making processes.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The hospital provided us with information which showed they used the updated National Quality Board Safe Staffing guidance and expectations for nursing staffing across the hospital and used the Safer Nursing Care Tool as a framework to decide on staffing numbers. Within the brain injury service, staff told us they aimed to comply with British Society of Rehabilitation Medicine (BSRM) guidelines in nurse staffing ratios and reported on compliance internally and to external commissioners.

Good

Medical care (Including older people's care)

On Wolfson Ward, we were told managers ensured there were enough staff on duty to keep patients safe. There were two registered nurses (RNs) during the day shift and one at night, plus one floating nurse between Wolfson and Wellesley wards. The ward manager was counted in the ward numbers for two days and supernumerary for another two days in week.

On the day shift, there were four team healthcare assistants (HCAs), and another four on one-to-one duty, in addition to one floating HCA to assist with mealtimes. There were five HCAs at night; two in the Team and three on one-to-ones. There were vacancies for two nurses and two healthcare assistants. Agency staff were used daily and substantive staff regularly did bank shifts.

On Chatsworth Ward on the day shift, there were four nurses, nine HCAs on long days, two HCAs on early shift and one HCA (NVQ trained) working 7.45PM- 4PM. On the day of the inspection, the ward was short of one nurse, due to them calling in sick. The ward manager was working clinically, in order to cover the staff absence due to sickness. Staff attempted to fill the vacancy with an agency nurse, but none was available. We were told that the ward normally operated with a ratio of one nurse for seven patients and this allowed good quality care to be delivered. Patients on the ward were highly dependent and HCAs were competent to escalate concerns to nurses.

Managers accurately calculated and reviewed the number of nurses and healthcare assistants needed for each shift in accordance with national guidance. During our inspection the number of nurses and healthcare assistants matched the planned numbers. We reviewed the nursing rota on each of the wards we visited, and these showed the service had enough registered nurses on duty on most shifts. The service used a mixture of its own staff and regular agency staff to fill empty shifts.

There was a high number of nursing vacancies within the nursing team. Recruitment of staff was ongoing and new nurses were scheduled to begin in post soon. The hospital regularly used agency nurses and substantive staff nurses regularly did additional shifts as bank nurses within the hours permitted. We were shown how agency staff were requested electronically. A matron for Safe Staffing supported all of the wards with staffing issues and oversaw Safe Staffing across the hospital, reporting directly to the Director of Nursing. Safer staffing is managed via an electronic reporting tool.

Managers made sure all agency staff had a full induction and understood the service. We were told the agency staff were given an induction checklist on their first day which included orientation to the area, where it was safe to go and not go and when and where all the equipment was kept, including resuscitation equipment. Most of the agency staff we spoke with had been working for a long time with the service.

The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service used British Society of Rehabilitation Medicine (BSRM) guidelines to benchmark and review allied health professional staffing, in line with patient complexity scores. The department manager could adjust staffing levels daily according to the needs of patients.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The provider told us that during regular working hours there were enough medical staff present, often with a senior GP from the Wandsworth Medical Centre (the practice providers for the hospital). GPs provided care for patients in the

continuing care wards. There were 4.2 WTE medical consultants, with at least one consultant on site from 9am to 5pm Monday to Friday. One of the consultants was also contractually responsible for providing specialist support to all GPs. The consultant led weekly wards rounds, which included a nurse and allied health care professionals. There were also weekly multidisciplinary team meetings, which included doctors, nurses, physiotherapists, neuro-psychologists, occupational therapists and speech and language therapists, as required.

The hospital had an interim medical director (MD) who had been in post for about four weeks before the inspection. He was an existing medical consultant who was familiar to the hospital and had worked at the RHN for a number of years. The MD chaired the monthly Mortality Review Committee (MRC) meeting, which reviewed all patient deaths and had membership of an independent Medical Examiner. The MD did not chair the last clinical audit committee, due to the interim nature of the role and clinical commitments. A new MD was planned to commence in November 2021 and will be chairing the clinical audit committee.

There were visiting consultants who had expertise in different specialisms such as palliative care, respiratory, neuro psychiatry, urology and Huntingdon's disease. During out-of-hours, there was a consultant in rehabilitation and a junior doctor on call. The junior doctor on call reported to the consultant on call as required.

The hospital had a schedule for doctors covering the wards during the day and the on-call rota out-of-hours. The neuropsychiatrist attended the wards weekly, to review medicines and lead the ward round; and was contactable in emergencies. On Drapers Ward, there was one consultant and two clinical fellows, working 9AM - 5PM, covering two medical teams. The consultant's leave was covered by another consultant in the hospital. If the clinical fellows had long term leave, this was covered by a locum.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. A mix of paper and electronic patient records were in use. Electronic records had secure access through a password system. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

We reviewed five patients records and found that they were all fully completed, clear and up to date. The service also carried out a record keeping audit every three months, by selecting 25 random patient's records, auditing compliance with legibility, consent, physical examination, treatment plan, treatment notes, surgical checklist, observational operative notes and discharge time. The most recent audit dated July 2021, showed the majority of the parameters were 100% compliant. Of the parameters that did not meet the 100% compliance target, these were highlighted for learning and future monitoring. Any outstanding actions and learning opportunities would be disseminated to staff in order to share the learning.

All staff were able to navigate the electronic system with ease. All computers were logged off when not in use. This meant patient records were kept secure and confidential.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Good

Medical care (Including older people's care)

The service had in-house pharmacy services for the Brain Injury Service only, they had contract with an external pharmacy under service level agreement for the provision of other pharmacy and medicines related services. The pharmacist carried out daily stock checks, removed unwanted medication and reviewed medicine charts. Senior staff told us that they liaised with the pharmacist and conducted audits of any medicines in stock to ensure any unused items were returned and stock levels did not become too high. Staff were able to contact the pharmacist to order stock when needed. Medicines were stored neatly in a locked cupboard. We saw robust checking of medicines, including dates and removal and entry from the cupboard. Medicine fridge temperatures were monitored daily. Appropriate actions were taken when these were out of normal range.

The medical director was the Controlled Drugs Accountable Officer, and the lead for the safe and secure handling of medicines was the senior pharmacist. The senior pharmacist reported to the medical director as the board member accountable for pharmacy services. The medical director chaired the medicines management committee including drugs and therapeutics committee, which fed up to the board through the patient safety and quality committee.

Pharmacists at the service carried out medicine's reconciliation with all patient medicines. Medicines reconciliation is the process of identifying an accurate list of a person's medicines and recognising any discrepancies and documenting changes. This is to ensure that new medicines were prescribed with a full understanding of current medicines. The service aimed to have medicines reconciliation completed for 95% of patients on a weekly basis.

Patients individual medicines were kept in their rooms in locked cupboards. On Wolfson Ward, stock medicines were stored in the clinical room, which had restricted access to registered nurses only. On Chatsworth Ward, medicines were requested monthly and each pair of patients had their own medicine cupboards, labelled with their names. Nurses disposed of unwanted medicines in green pharmacy returns box. Long-term medicines were supplied from an external pharmacy and short-term medicines were supplied from the internal pharmacy.

Nurses were trained to administer IV fluids and IV antibiotics. The training consisted of an online module and competency assessment on the ward in line with the national competency best practice framework's IV Therapy Passport. The ward manager checked medicines charts six-weekly. We were told there were good relationships between doctors and nurses.

The GP attended the ward every day to review medicines and patients during 9AM - 5PM. Out-of-hours, this was done by an on-call doctor. ' Whenever necessary' medicines (PRN), were reviewed monthly or as required by the doctor.

We saw evidence that medicine audits were carried out monthly by nurses via the 'Perfect ward' app, available on smartphones and tablets. The latest medicine audit we saw, had a score of 83.9% compliance with the standards, however, this was below the hospital target of 95%. If antibiotics were prescribed out-of-hours, these were obtained from the hospital's pharmacy central stock. Medicines were prescribed for individual patients and controlled drugs were kept on the wards and were patient specific. Medicines were administered by nurses at prescribed times and recorded on the electronic record system, which all nurses had access to.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Medical care (Including older people's care)

Staff knew what incidents to report and how to report them. They followed clear guidelines and could describe the process for reporting incidents. Staff reported serious incidents clearly and in line with the hospital's policy. All staff we spoke with were clear about their duty to report incidents and knew how to do so using the electronic reporting system. Staff understood the duty of candour. When incidents occurred, that required the Duty of candour policy to be followed, the hospital complied with the procedure. However, staff knew they needed to be open and transparent, and gave patients and families a full explanation if things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff followed a clear process for reporting and investigating incidents. Staff received feedback from investigation of incidents, both internal and external to the service. Managers held quality improvement meetings, where they shared lessons learned with staff. They recorded this in meeting minutes.

There were weekly and monthly incident review meetings to examine all actions following an incident. Managers held clinical governance meetings and quality improvement meetings every month, during which they discussed recent incidents. Our review of minutes of the meetings showed how patients and families were involved in these investigations.

Learning from safety incidents or safeguarding concerns is shared across the service so that all staff learn lessons.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service was not required to use the NHS Safety Thermometer as they are an independent healthcare provider. This is a tool which measures harm to patients which may be associated with their care. We saw Putney Boards on each ward that displayed the data relating to performance in these key areas. The "Putney Board" had information on quality and safety of the service, these include infection rates, falls, hospital acquired infection, staff comments and suggestion cards and patients feedback comments.

The hospital performed well in the safety thermometer. In August 2021, the service showed 100% overall score for harm free care. We saw safety thermometer results were displayed on the wards we visited for patients, their relatives and visitors to see. On some wards, such as Drapers and Jack Emerson, staff discussed safety thermometer results during handovers. We also saw "Putney Boards" being discussed during afternoon huddles.

Are Medical care (Including older people's care) well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good

Medical care (Including older people's care)

Leaders had a shared purpose and strived to deliver and motivate staff to succeed. Staff told us leaders were visible and approachable. Leaders now had oversight on quality and how the service was managed. Since the last inspection, there had been some changes at executive level, which were the appointment of a new director of nursing and the recent retirement of the former medical director. The organisation had reviewed their safeguarding, governance and quality structure and had recruited a new Head of Safeguarding and an operational lead for safeguarding with strong safeguarding experience.

There was a clear organisational structure within service, with newly developed service lines to ensure clear lines of reporting and improved governance across the five specialty areas. Staff told us they felt supported by both their immediate line managers and the senior management team. Senior leaders worked together to support staff and improve the patient experience, with daily briefings to ensure that key messages, successes and goals were shared across the hospital.

The organisation had invested in external leadership training for its' senior managers, including members of the Board. This training had been commissioned and delivered to 25 senior staff within the hospital.

Staff we spoke with were very positive about the current leadership of the hospital. They told us that their managers were approachable and visible. All staff we spoke with, spoke highly of the current local leadership. Staff knew all their managers and their areas of responsibility. Staff said they felt supported and gave examples of when they had received support with personal circumstances. During the inspection, we observed positive interaction between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

The leadership for patient safety and safeguarding is clear and there was a clearer thread of oversight from ward to Board. Patient safety incidents and safeguarding were discussed and reported to the senior leadership team on a weekly basis. All incidents were reported on each ward along with action being taken. This also acted as an early warning system for any emerging themes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Staff supported the vision for the hospital to become a centre of excellence in acquired brain injury, including its research function. A new service model was in place. Financial stability and developing staff competencies were the focus of the leadership team. Families were at the centre of developing the hospital's vision. The hospital prides itself on caring for patients as individuals, offering hope, practical and emotional support to them and their families.

The vision and strategy were focused on providing family centred services, community focus, and personalised care, provided by high performing multidisciplinary teams. At the time of the inspection, the vision and strategy was being refreshed. The current vision 2022. There was a quality improvement plan which was built upon the experience and priorities of the service during the COVID-19 pandemic and beyond. There was a clear commitment by the leadership team to improving the patient experience with the involvement of frontline staff.

The mission/vision of the of the hospital was to meet the needs of people with complex disabilities which had arisen from a profound brain injury and providing services for adults with acquired brain injury. The hospital provided specialist care, therapies and innovative technology to meet the complex needs of people with profound disabilities, caring for patients as individuals, offering them hope, practical and emotional support to them and their families.

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The service's objective of finding 'ability in disability' was understood and supported by families and staff. Staff spoke of the challenges of helping relatives to have realistic expectations while maintaining hope. They said the new management was more open and had improved communications.

The hospital had a different vision and strategy for each of their specific business areas such as nursing, fundraising, research and clinical strategy. Each strategy was authored and led by members of the executive team. Staff knew about the plans, vision and strategy for their ward and could explain what it meant for their work. For example, staff told us of plans to expand the ventilator unit, wider participation in the Putney programmes, and improving electronic systems particularly in relation to electronic patient records.

At the time of the inspection, the Board was leading a formal review of its' future strategy, engaging all staff, to ensure that it was relevant and reactive to the current needs of the local, and wider, population. Various members of the senior leadership team outlined a clear plan of how this strategic plan was to be developed over the coming months.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were open and transparent throughout the hospital during the inspection. We were told that the director of nursing had an open-door policy and senior management were approachable and supportive. Staff knew how to raise concerns about bullying and harassment, although nobody reported this as an issue during the inspection. In the current staff survey 100% of respondents reported that they knew how to raise a concern. Staff knew how to report incidents and felt supported when they did this. Managers used incident outcomes to improve and embed new training. Staff we spoke to did not feel they were blamed when things went wrong.

A senior nurse told us they enjoyed working at the hospital. They said all colleagues were supportive and there were lots of opportunities to develop and learn. Most staff felt supported by their colleagues and managers. They said there was good teamwork and most staff worked as one team. They made comments such as "staff are amazing" and "teamwork is great". Both doctors, allied health professionals and nurses said they had good working relationships with each other

A ward manager told us they enjoyed working on the ward. They said they had good relations with patient families and spent time with them during visiting times.

Managers used several platforms to inform staff of the outcomes of serious incident investigations. Incident investigation reports were shared with all staff. Staff were also sent email updates of changes to practice by the chief executive. The Chief Executive also produced a weekly video for staff, patients and families which was also publicly available on the RHN website.

Staff we met on the inspection were welcoming, friendly and helpful. Staff told us the culture was supportive and caring and they were confident to speak up should they have any concerns. There were three freedom to speak up champions within the hospital to help staff to speak up, reporting to a Freedom to Speak up Guardian who was a Trustee and member of the Board. Staff could contact that person if they had concerns.

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Staff we spoke with had a strong commitment to their jobs and were proud of the team working within the hospital, positive impact on patient care and experience, and improvements they had made to the service since the last inspection. Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff felt respected and that they could approach any member of staff and challenge inappropriate practice or behaviour if necessary.

Patient quality surveys were done to allow families to express their experience of care.

The organisation had made a conscious effort to review out of hours working arrangements to identify staff working on permanent nights to ensure that this working practice was reduced, where staff continued to work nights, they were rotated around the hospital. Addressing out of hours culture is an important factor in guarding against the development of closed cultures.

Governance

Some leaders had oversight of governance processes throughout the service. Staff at senior management levels were clear about their roles and accountabilities.

We spoke with a member of the Executive Management Team on the day of inspection, who confidently described the clinical governance process – identifying how risk and quality flows from ward to board through the providers formal and informal routes.

Service meetings were held monthly with each service area, where the vision of the service was discussed. Wards areas had monthly meetings with their executive buddy. Agreed discussion points and issues of concern were escalated to the patient safety and quality committee, which is a Board Committee and reports directly to the Board.

The service had improved their governance processes since the last inspection. They had had an increased focus on patient safety and safeguarding. The service delivery teams had been divided into five service areas, additional had been brought in to strengthen knowledge. This included the introduction of a safeguarding committee. There was an acknowledgement of the need to be transparent with external partners to ensure best practice. The level of scrutiny from ward to board was now very structured with positive feedback from their external partners. For example, the hospital's current safeguarding referral audit showed compliance with safeguarding referral requirements from the local authority. The management team ensured that safeguarding issues that were raised were discussed at executive team meetings.

We were told there was a patient representative committee (PRC), that met quarterly. The PRC was chaired by a member of the Board of Trustees. Other members of the committee were a trustee with experience as a relative, and a representative for each ward, either a patient or a relative. Feedback and learning discussed at the PRC was shared with everyone at the hospital. We were told about the patient safety and quality committee, which met quarterly and was chaired by a trustee, and included a former patients' relative and a former patient in the membership. The committee reviewed feedback from patients and relatives, analysed trends and shared learning across the hospital.

The service undertook an annual review of complaints and outlined actions to be taken. There was a weekly patient safety and quality executive meeting and complaint responses were presented at this meeting. There was a weekly Serious Incidents, Complaints and Safeguarding meeting, led by the Head of Patient Safety & Quality Assurance and co-chaired by executive team members, where staff were updated on ongoing serious incident investigations, as well as

new and ongoing safeguarding cases. Quarterly reports on complaints were also completed and shared with the executive team. The patient experience and safety officer (PESO) managed formal complaint responses and oversaw the response team to ensure deadlines were met. The PESO also dealt with informal concerns that were raised by patients and relatives and provided feedback to them as appropriate.

We were shown an updated draft board assurance framework (BAF), which went beyond the committee structure (as per our previous inspection findings). Whilst some progress has been made since the previous inspection, the provider should finalise their review of the BAF, so that it is updated and approved by the board.

We noted that some of the board sub-committees' terms of reference (TOR) were out of date. Leaders informed us that this had been a conscious decision as a result of them focusing on the pandemic response. We asked a senior leader whether a revised schedule of dates for board sign-off of TORs had been approved and we were advised this was the case. However, the provider sent us evidence that showed that TORs were reviewed in their entirety in October 2019 and the latest amendment was made by the board in January 2021, when the quorum of the Patient Safety and Quality Committee was revised. We were therefore concerned that there was a disconnect between what we were showed and told during the inspection and what the provider sent in later, which was clearly available at the time of the inspection.

There was a lack of transparency of board meetings and minutes, because these were not available to the public. Although this is not a mandated requirement, transparency of governance is a key pillar in strong corporate governance; when considering the fundamentals of good governance as indicated in best practice (Good Governance Institute as an example).

The safeguarding policy was aligned to that of the local CCG. The service had achieved all of the seven standards of NHS England's Safeguarding Accountability & Assurance Framework (SAAF).

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were assurance systems at the hospital. Managers escalated performance issues through clear structures and processes. Senior leaders told us key managers met weekly to discuss any serious incidents, complaints, governance and safeguarding issues.

The hospital had an incident register, which contained every incident that had been reported on the incident reporting system and staff tracked any changes made as a result of the incident. We saw there was evidence of this document being updated on a regular basis, and that actions identified were reflected in the practice we saw. Clinical staff told us they were aware of the incident register, that they discussed it at every team meeting and were able to tell us changes that had been made as a result of recent incidents. We saw the current risk register and noted the risks were clearly documented and there were mitigations and evidence of them being regularly reviewed.

The hospital management used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Managers had plans to cope with unexpected events. A number of initiatives to address performance issues were introduced after the last inspection, and this had a positive impact on their performance. This meant that delivery of safe care was done in a timely manner. Several clinical audits were done using the "electronic digital application (App), we were told by a ward manager that this had made a big difference in the clinical audit regime of the hospital.

There was a risk register for the hospital which was divided into organisational, clinical, medicines management, finance and information governance risks. Departmental risk registers were updated monthly and incorporated into the corporate risk register, which was reviewed at a minimum monthly by the executive management team. Risk registers were then reviewed by the relevant Board committee including the Audit and Risk committee quarterly; and then by the Board who also receive the executive's commentary on the risk.

The service had a risk management policy and strategy to implement the policy. The policy outlined how risks were identified and reviewed by the executive team and the board of trustees. The hospital identified its top risks as the safety of patients, the quality of care, recruitment and retention of staff and financial sustainability. These were broken down further into specific risks in the organisational risk register. We saw examples of where risks have been mitigated. For example, the risk of clinicians failing to recognise patients were deteriorating was mitigated by training, updating guidance and introducing an electronic observations system.

During the on-site inspection, we found the top three risks were displayed on the learning board on wards, and staff were able to explain them. The display also showed details on what mitigations were in place to address the risks. Ward managers told us risks were also discussed in handover meetings.

There was a weekly Potential Serious Incident and Safeguarding meeting to discuss all incidents reported the previous week and determine how each should be investigated, led by the Head of Patient Safety & Quality Assurance. Schwartz Rounds were held monthly. At the start of the first wave of covid-19 meetings were initially paused but soon resumed remotely.

A matron huddle was held each day. Patients with a NEWS2 score of 5 and above were discussed for the clinical priority list. During the huddle, staffing, incidents and safeguarding were also discussed. Matrons also met twice weekly with hospital directors, at the Stand Up Meeting of Operations (SUMO), to discuss any concerns at the time. Unresolved matters at the SUMO meeting, were escalated by directors to the board.

There was a clear structure of accountability and responsibility within the Safeguarding team and the Patient Safety & Quality Assurance team which both worked closely together. They offered assurance of the transparent approach to safeguarding incidents, serious incidents and complaints within the hospital and identification and reporting of concerns relating to those close to patients/visitors. There was strong oversight by the Director of Nursing of safeguarding activity. Structured and regular meetings with key local partners ensures the hospital was a key partner locally in the safeguarding system. This also offers support to the hospital from statutory organisations.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The service had an up-to-date confidentiality and data protection policy. This was an improvement from the last inspection.

On Wellesley Ward, a senior nurse told us the Putney Board was used to identify improvements. Weekly and monthly audits were done, as well as ward-based teaching.

Staff had electronic access to the information they required to do their jobs, including, incident forms, training, clinical guidelines and policies. Agency staff also had access to information electronically. During inspection, we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR). The service had a policy in place to guide staff on GDPR requirements and its implications for practice. Staff had completed training on information governance and GDPR. Staff had met their compliance target on information governance.

The CEO sent weekly emails to all staff, patients and families informing them of recent developments within the service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff were observed asking patients for their opinions on the service to ensure changes and improvements were made that would benefit them. Managers confirmed they did not carry out a staff survey in 2021. However, following the inspection, the provider told us that due to the constraints of Covid-19, data collection for the staff survey 2020 was extended to the end of 2020 until 31 March 2021. There were weekly meetings with staff, where they could bring up any concerns or ideas for improvements, including the use of Putney Boards, to flag any ideas they had. Clinical staff confirmed they felt able to bring up ideas for improvements at these meetings and could speak openly with managers and the senior leadership team. There was regular engagement and discussions with the external stakeholders to ensure patients had a seamless care pathway and good quality care.

People's views and experiences were gathered and acted on to shape and improve the services and culture. The service had several ways to engage with the public and service users, including social media feedback forums and a service user's suggestion box in the reception.

On Wellesley Ward, we were told patient relatives had daily involvement and were a big part of their rehabilitation. A family meeting took place two weeks after the patient's admission and discharge planning meetings involved family members.

Staff recorded the conversations they had with the family in the communication book.

We were told the hospital held an 'Experience of Care' week on an annual basis, where there were interactive boards and balloons; and patients were asked 'What brightens their day'. Patients, relatives and carers were encouraged to be as involved as possible.

We were told there was a communication working party group, which was run with patients, who also completed part of the workshop training. The PESO met with patients regularly to talk about communication methods and how poor communication made them feel. This project was supported by the Health Innovation Network. The PESO told us of guided learning for staff on how to manage telephone conversations. The PESO also assisted patients with completing surveys, utilising whatever communication aids were required.

We were told two trustees were involved in various patient experience committees, which also included ward representatives. We were given an example, whereby the father of a patient who died at the hospital, was now a trustee on the board as a ward representative. This was considered a good practice due to the nature of the patients who were been cared for at the hospital.

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The hospital participated in quarterly clinical quality review group (CQRG) meetings led by external commissioners. The purpose of the CQRG is to monitor the quality of services. Since December 2019, the CQRG had been held on a quarterly basis and included representatives from CQC. This was agreed by the CQRG membership and included in the Terms of Reference.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

In the Behavioural Specialist Services nurses were trained to chair incident de-briefing sessions with staff, in order to provide support and guidance, rather than require a neuro-psychologist to complete them. This was started three months ago. On all wards we visited, the Putney Board was used by the hospital, as a means of sharing learning, driving improvement and celebrating success.

We observed a Putney Board meeting on Drapers Ward. Present at the meeting were doctors, nurses, healthcare assistants (HCAs), domestics, the ward receptionist and the matron. This was a 10 minute meeting, which was timed. A recent incident was discussed when a relative was observed not wearing a mask on the ward as required. Staff discussed what should be done in such circumstances and what was learnt as a result. The Putney Board meeting was held twice per week on each shift on some wards, and once per week on other wards. Learning was shared amongst all MDT members. The top three risks were identified on Drapers Ward, and these were patient dehydration, medication errors and patient falls.

Headings on the Putney Board were shared learning, ideas and issues, improvement project, celebrations and successes, birthdays and thank you.

On Chatsworth Ward, we noted that staff added their ideas to the Putney Board on cards under 'Ideas and Issues'. The board also had the following headings: In progress, Implemented, Escalated, and You Said, We Did. Two examples of ideas placed on the Board by staff were (1) Handovers were too long, and (2) the ward needed decorating. As a result of these ideas, handovers were made shorter and the ward was re-decorated.

All staff members were given the opportunity to lead a Putney Board huddle and the Executive Level Buddy for each ward was also invited to attend. Feedback and ideas from the Putney Board huddle were shared with the service's matron and executive management team buddy, so that support could be given to each area to achieve their objectives.

On Wellesley Ward, staff did training in Positive Behaviour Management to understand and safely manage patient behaviours.