The Raphael Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Raphael Medical Centre is operated by Raphael Medical Centre Limited, an organisation which also provides social care services for people with acquired brain injuries. The Raphael Medical Centre is an independent hospital mainly specialising in the neuro-rehabilitation of adults suffering from complex neurological disabilities with cognitive and behavioural impairment.

The long term conditions service at the hospital focuses on the care, treatment and rehabilitation of people with acquired brain injuries. There are facilities to accommodate a total of 50 patients. There is space for 33 patients in two wards in the main building, and nine patients in Tobias House which is designated as an area for the treatment of prolonged disorders of consciousness. There is further capacity to treat eight patients in the special care unit for neurobehavioral rehabilitation and this unit also accommodates patients admitted under the Mental Health Act. Facilities available at the hospital included a physiotherapy gymnasium, a hydrotherapy pool, therapy rooms, consulting rooms and common areas.

We inspected the long term conditions service using our comprehensive inspection methodology. We carried out the inspection on 6 and 7 February 2017.

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

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

Overall we rated the long term conditions services at Raphael Medical Centre as requires improvement because:

- We had concerns regarding some aspects of patient safety. This related to some areas in medicine storage, the environment and shortfalls in infection control procedures.
- Although there were suitable systems to report and investigate incidents and complaints received, staff did not consistently receive feedback on either. Additionally we saw no evidence of lessons learned.
- The provider did not provide assurances that doctors working under the rules of practising privileges had appropriate references and criminal checks as per their policy and best practice guidelines.
- The audit plan was not fully embedded and we were told it was in the process of being redesigned. This meant staff were unable to monitor performance and areas of risk.
- Risks and issues identified were not sufficiently monitored or documented. For example some audits were being carried out but the provider was unable to show the results of these were consistently acted upon or used to improve service.
- The management team had a lack of knowledge and no plan in place to implement the Workforce Race Equality Standard (WRES) requirement.

However:

- We found treatment followed current national guidance. The hospital had policies and guidelines in place for most areas of the hospital.
- Patients were cared for by a multidisciplinary team working in a cohesive way and generally had access to service seven days a week.

Summary of findings

- We found there were arrangements to ensure nursing, therapists and support staff were competent and confident to look after patients.
- Patients' dietary and nutritional needs were met and were supported appropriately when problems occurred.
- Consent was obtained and recorded in patients' notes in line with relevant guidance and legislation. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligation under the Mental Health Act.
- We observed compassionate care that promoted patients' privacy and dignity. Patients and their relatives were involved in their care and treatment and were given the appropriate amount of information to support their decision making.
- Discharge planning was started upon a patient's admission.The service encouraged and supported social reintegration from the point of admission. The provider acknowledged end of life care, advance care planning and the recognition for emotional support and spiritual needs of the patient.
- The arrangements and quality of leadership had improved. Committee meetings identified areas of concern and acted to address these. Delegation of duties had been passed to directors and managers to empower staff to make decisions for the good of the hospital and its patients.

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

Professor Edward Baker
Deputy Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to The Raphael Medical Centre

Raphael Medical Centre is operated by Raphael Medical Centre Limited. The hospital opened in 1983. It is a private hospital in Hildenborough, Kent. Referrals are accepted from across the south-east of England. The majority of referrals are received from Clinical Commissioning Groups (CCG's) for NHS patients. The hospital also accepts private patients funded by patients themselves or insurance companies. The hospital specialises in the neurorehabilitation of adults following acquired brain injury. It provides a service for people over the age of 18 years, both male and female, and does not treat children or young people.

The hospital states its services are based on a desire to ensure a peaceful and tranquil environment is created which helps people to move from a state of medical dependency to reach their optimum level of functional independence. The service principle is a holistic one based on the anthroposophical image of man, which recognises man as being of body, soul and spirit. Therapies include art, music, oil dispersion and physiotherapy.

The Raphael Medical Centre is registered with the Care Quality Commission to provide the following regulated activities:

- treatment of disease, disorder or injury,
- diagnostic and screening procedures,
- assessment or medical treatment for persons detained under the Mental Health Act 1983.

The hospital has had a registered manager in post since1983. There is a Controlled Drugs Accountable Officer at the location.

The service employs about 151 whole time equivalent clinical staff including doctors, nurses, therapists and rehabilitation assistants. The hospital also has stepdown accommodation and this was not inspected. The service does not provide imaging or pharmacy services.

The last inspection of this service was in November 2015, when it formed part of a pilot for the new methodology for long term conditions. This meant that the service was not rated. Following the inspection, we had concerns about some aspects of patient safety. We identified concerns in relation to the environment, arrangements to identify and support patients whose condition is deteriorating and shortfalls in infection control procedures. Staff did not receive feedback from incidents reported. Complaints and incidents were investigated although systems to learn from outcomes were insufficient. The hospital employed doctors working under practising privileges but was unable to provide a formal agreement that set out the rules and conditions of their employment. The hospital's policies did not reflect national guidelines; they did not acknowledge end of life care, advance care planning and the recognition for emotional support and spiritual needs of the patient. There was a governance structure but performance and risk issues were not monitored. The management culture was directive and there was limited delegation of responsibilities. As a result of these concerns, we issued two warning notices under regulation 17 (good governance) and 12 (safe care and treatment). We have since monitored the hospital to ensure that it was taking steps to address these issues. The service has provided us with extensive documentary evidence to demonstrate they had addressed our concerns and the relevant regulations were being met. We reviewed this information in detail.

On this inspection we inspected the whole service and paid particular attention to those specific areas where there had been a breach in the regulations to ensure the necessary changes had been made and the service was now compliant with the relevant regulations.

We have identified improvements in the service. We have seen significant changes in key areas to keep people safe and provide effective well led care. However we found these had not been fully embedded throughout the hospital. We were told the provider was in the process of redesigning several areas including incident reporting, audit programme, risk management and board assurance framework.

Summary of this inspection

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, a pharmacist inspector and five specialist advisors with expertise in neurorehabilitation, brain injury, facilities management and community nursing. The inspection team was overseen by a CQC Inspection Manager.

Information about The Raphael Medical Centre

To help us understand and judge the quality of care at Raphael Medical Centre we used a variety of methods to gather evidence. During the inspection, we visited all clinical areas within the hospital. We spoke with 32 staff members including; registered nurses, health care assistants, reception staff, medical staff, therapists and senior managers. We observed the environment and the care provided by medical, nursing, therapists and support staff. We spoke with nine patients and three of their friends and family. We looked at a range of documents, including audit results, action plans, policies and management information reports. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital. During our inspection, we reviewed 20 sets of patient records.

In the reporting period October 2015 to September 2016 the hospital received 63 referrals for admission. At the time of inspection there were 48 patients with a further ten in the stepdown accommodation (not inspected). The majority of patients (95%) were NHS funded.

There were eight patients on the neurobehavioural rehabilitation ward (for patients with dual diagnosis and mental health issues), 24 patients on the acute neurorehabilitation ward (for patients with complex degenerative neurological conditions), nine patients in Tobias House (for patients with disorders of consciousness) and nine patients in the continuing healthcare ward (for slow stream neurorehabilitation).

Six doctors worked part time at the hospital under rules or practising privileges. One doctor was directly employed full time and another one worked full time via an agency. There were 30 nurses who worked full time and four part time. The hospital also employed 16 therapists, 19 other allied health professionals and 85 health care assistants. The hospital made use of both bank and agency staff when necessary.

In the reporting period October 2015 to September 2016 the hospital reported no Never Events and no Serious Incidents. In the same period, the hospital recorded eight pressure ulcers, 25 falls, 42 urinary tract infections and one hospital acquired VTE.

The hospital reported eight incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), and no incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA). There were no incidences of hospital acquired Clostridium difficile (c.difficile) and 60 cases of other bacteraemia.

The hospital received seven written complaints October 2015 to September 2016, three of which were managed under the hospital's formal complaints procedure and all were upheld.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Although there were many good things about the service, it breached a regulation relating to Regulation 12: Safe care and treatment. Medicines were stored appropriately with the relevant checks in place, however actions were not always recorded when discrepancies were noted for medicine fridges which fell outside the required temperatures. This could impact on the safety and efficacy of medicines.
- Although staff had a clear understanding of their role in reporting incidents, investigations when incidents occurred were not effective and learning was not widely disseminated. Staff reporting incidents did not always receive feedback. However, the provider had improved the policy and process since the last inspection.
- There was limited measurement or monitoring of safety performance. The hospital did not follow best practice guidelines from the Department of Health. This related to shower heads, carpets, wall surfaces and waste. The hospital had a strategic plan and policy for cleaning, however these plans were not adequate as they did not provide guidance for staff.
- The hospital had a risk management policy for business continuity planning and a 'human side of business and technical plan'. However, these plans were not adequate as they did not provide guidance for staff in the event of a disaster.

However:

- The hospital was visibly clean and tidy. Staff in all areas used appropriate hand hygiene techniques and complied with the hospital's policies and guidance on the use of personal protective equipment.
- Mandatory training was being completed which meant staff had the necessary current skills to do their job. Staff were aware of their responsibilities concerning the protection of people in vulnerable circumstances.
- We saw there were processes for regular equipment checks both from internal and external maintenance sources and a clear preventative maintenance process.

Summary of this inspection

- Confidential patient records were securely stored. Records showed patients were risk assessed in key safety areas using nationally validated tools and goals set according to national guidance. Additionally, an early warning system for the deteriorating patient was used.
- All patients were under the care of a consultant for their relevant conditions. Nursing therapy and medical staffing levels adhered to relevant guidelines such as the British Society of Rehabilitation Medicine (BSRM) and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.

Are services effective?

Good

We rated effective as good because:

- We found care and treatment reflected current national guidance, standards, best practice and legislations relevant to rehabilitation services. Patients were screened for the risk of malnutrition, and patients who received artificial support, via feeding tubes, were reviewed regularly by the speech and language therapists.
- There were formal systems for collecting comparative data on patient outcomes. Information on rehabilitation requirements was collected as a multi-disciplinary team and sent monthly to United Kingdom Specialist Rehabilitation Outcomes Collaborative (UKROC).
- Staff worked together effectively to provide comprehensive care to patients. We saw data which confirmed staff received an appraisal. There was a formal system to track themes or trends identified.
- Care was provided consistently throughout the week. The day to day medical service was provided by the in house physicians during the day and an on call service between 8pm and 8am. Consultants provided a 24 hour on call service. Patients had access to therapy services seven days a week 8am to 8pm.
- We saw there were clear procedures for patients subject to the Mental Health Act as well as for Deprivation of Liberty Safeguards (DoLS). The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decision making process complied with national guidelines.

However:

- The provider did not provide assurances doctors working under the rules of practising privileges had appropriate appraisals, references and disclosure and barring service (DBS) checks as per their policy and best practice guidelines.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.
- Feedback from patients and those close to them was positive about the care provided from all staff they interacted with. Staff treated patients courteously and with respect.
- Staff involved patients in their own care and treated them as partners. Each patient was assigned two key workers who worked opposing shifts to provide continuity of care for patients. Patients were supported to increase and maintain their independence.

Are services responsive?

Good

We rated responsive as good because:

- The provider understood the needs of the patients it served. It designed services to meet those needs which included active engagement with commissioners, families and carers and other healthcare agencies. Patients received care and treatment in a timely way. There was a proactive approach to managing referrals, assessments, admissions and discharge from the service.
- Patients and those close to them had the information they needed and were supported to provide feedback or make a complaint. Complaints were taken seriously, investigated and resolved.

However:

- Complaints showed there was no evidence of discussion with staff involved or changes made owing to the outcome. Additionally, lessons learned were a broad statement and there was no evidence this was shared with staff.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Risks and concerns identified were not sufficiently monitored or documented. For example, some audits were being carried out but the provider was unable to show that the results of these were consistently acted upon or used to improve the service.
- The management team had a lack of knowledge or a plan in place to implement the Workforce Race Equality Standard (WRES) requirement.

Summary of this inspection

- The hospital did not have suitable governance arrangements in place for the monitoring of doctors worked under practising privileges agreements.
- The hospital did not have a current staff survey to collate the views of staff.

However:

- The vision of the hospital was to provide and develop a rehabilitation medical hospital, based on the anthroposophical image of humans which recognised humans as being of body, soul and spirit. Staff understood this philosophy and were supportive of it.
- The arrangements and quality of leadership had improved since our last inspection. Committee meetings identified concerns and took action. Duties had been delegated to directors and managers to empower staff to make decisions for the good of the hospital and its patients.
- Leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. Staff said managers were available, visible, and approachable.
- The unit had a strong focus on continuous learning and improvement and staff innovation was supported. Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Long term conditions

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

Are long term conditions safe?

Requires improvement

We rated safe as requires improvement.

Incidents and safety monitoring

- The hospital reported three incidents of patient death between October 2015 and September 2016. All of these were patients who were subject to an authorisation to deprive them of their liberty from a supervisory body or the Court of Protection.
- No never events or serious incidents were reported by the hospital between October 2015 and September 2016 as none had occurred. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Incidents were investigated by the management team to establish the cause. Mortality and morbidity incidents were discussed as part of the Medical Advisory Committee (MAC) meetings which met every four months. The MAC reported to the clinical commissioning group (CCG). These were then reported to other relevant organisations as required, for example CQC.
- The hospital had an updated incident reporting policy 2016, authored by the director of nursing and approved by the CCG. The policy contained the role of the provider and staff in the event of an incident. It included examples of an incident reporting form and a flow chart to advise staff of the process. In the event of an incident all staff were to report to their line manager and record all facts on the form which was passed to the patient safety team. The team, led by the director of nursing, participated in the appropriate investigation to ensure learning and improvement was identified and disseminated across the hospital. The team was also required to provide assurance to the CCG the reporting arrangements were adequate and appropriate.
- At our last inspection we told the provider they should monitor and investigate all incidents, document lessons learned, disseminate this information to staff and provide feedback. Managers told us, and we saw in the June 2016 CCG meeting, the patient safety committee correlated all incident forms. This information was made available for all staff on a database on the hospital's computer system to keep staff informed of lessons learned. Additionally, appropriate feedback to be provided to the person who reported the incident.
- We saw the incident reporting process had been embedded across the hospital. Incidents were discussed at team meetings. We saw a hard copy of the incident reporting policy was kept in the nurse's office on Level 1 ward of the main building. All staff on the ward had signed to say they had read the policy. Staff gave us examples of how they reported incidents and told us the provider encouraged them to report incidents to help the whole organisation learn. Staff gave us examples of incidents they had reported and these related to patient falls, pressure ulcers and challenging behaviour.

Long term conditions

- We were given the example of a member of staff who reported an incident of challenging behaviour and was supported by the nurse in charge the following day. They told us learning outcomes were discussed and they reflected on their management of how to handle patients at that point in their care differently. However, other staff told us they did not they did not receive feedback following an incident and incidents were not discussed at staff meetings.
- We saw the minutes of team leaders meetings for May and December 2016. Learning from incidents was shared and then discussed at ward meetings. Therapy staff told us incidents were discussed at the monthly therapist meeting. We saw the minutes for June and August 2016 meetings. Both minutes referred to lessons learned from incidents and were available for staff to view on the hospital's internal computer system.
- We asked the provider for data of reported incidents. We were provided with data of 89 clinical and seven non-clinical incidents between February 2016 and January 2017. An increase in the number of incidents reported suggested a good reporting culture throughout the hospital. The provider explained the analysis of incidents had started to be embedded throughout the hospital in June 2016.
- During the inspection we reviewed the incident log, which documented the details of 11 incidents. The date, time, category, location of incident and lessons learned were recorded. It was not indicated if lessons learned were shared with staff.
- We looked at five of the incident forms in detail. We saw two incidents were graded as moderate harm (requires significant treatment but not permanent harm) and three as minor (short term injury). There was no evidence of any investigation in any of the incidents we looked at. Three incidents had no documentation of lessons learned and one of these was graded as moderate. We found two incidents had documentation of lessons learned and no indication if this had been shared with staff. One incident related to staff who had removed a patient's feeding tube accidentally. The lessons learned were recorded as 'staff should be careful not to pull out the tube'.
- The director of nursing was lead for patient safety and part of this role was responsibility for the reporting and monitoring of incidents. We discussed with the director of nursing if the present system was adequate and suitable for all staff to progress from lessons learned. We were told the system was not adequate and they were in the process of strengthening the system with an accessible database and updated report form. This was not in use at the time of inspection.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken. We reviewed a sample of hospital clinical incidents, patient's notes and analysis and saw evidence that staff had applied the duty of candour appropriately.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital monitored patient safety to enable them to measure, assess and analyse any incidents of harm. These were regularly monitored and reported to individual teams and key committees.
- Data collected related to falls, urinary tract infections (UTI) in patients with a catheter, venous thromboembolism (VTE) and pressure ulcers. Data showed between October 2015 and September 2016, eight pressure ulcers, 25 falls, 42 urinary tract infections and one incident of VTE were reported.
- The provider had introduced a process to reduce the incidents of UTI's. The director of nursing told us every patient had their urine tested weekly according to UTI protocol and care pathway. We saw five records on level 1 ward in the main building, which showed the weekly testing of urine was completed in every case. This was completed by the key worker every Wednesday. Any anomalies were reported at handover.

Requires improvement

Long term conditions

Systems, Processes and Practices

Mandatory training

- We saw the training records for staff (excluding medical staff) for mandatory training. We spoke with managers who monitored the completion of mandatory training for their teams. We saw they had electronic systems, which recorded the training that was required, and its completion dates. Managers described how they used the system to ensure staff remained up to date.
- We reviewed the data which showed the attendance rates of each department for staff who had attended all relevant mandatory training in 2016. The target set by the hospital was 100%. This included domestics and laundry (99%), kitchen and maintenance (98%), administration (100%), clinical staff in the main building (96%), Tobias House (98%), special care unit (96%), therapists (90%) and senior management team (100%).
- The training programme was comprehensive and contained all the training subjects that would be expected. For example, safeguarding, challenging behaviour, health and safety, infection control, Mental Capacity Act, Deprivation of Liberty Safeguards and fire safety. Throughout the year there were two different topics covered each month.
- The practice of neurorehabilitation was not part of mandatory training contrary to recommendations of the Independent Rehabilitation Providers Alliance.

Safeguarding

- The hospital had safeguarding policies for both children and vulnerable adults. We saw all staff were provided with safeguarding training with annual updates. All clinical staff were trained to level 2 and non-clinical to level 1, which was in line with their policy. Senior staff (team leaders and lead therapists) were required and supported to attend external training.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was.
- The safeguarding committee met every three months to discuss issues around safeguarding including the following up of referrals made. Minutes were taken and feedback given to staff. At the last inspection in November 2015, we found the safeguarding lead actioned all areas of a safeguarding concern with staff showing limited knowledge of their responsibilities. On this inspection we found the safeguarding lead, although still taking overall responsibility, had delegated roles to other staff. Ward managers were trained to level 4 safeguarding children and the lead maintained an advisory role. This meant staff throughout the hospital took responsibility for safeguarding concerns.
- Safeguarding reports were kept in individual patient's records and a copy was kept in a central file held by the safeguarding lead.

Infection control and hygiene

- Before the inspection we requested data regarding hospital acquired infections. Between October 2015 and September 2016 there were no cases reported of C.difficile related diarrhoea or MSSA bloodstream infections. There were eight cases of MRSA, one surgical site infection and 60 cases recorded as 'other bacteraemia' infections. The MRSA infections were acquired before patients were transferred to the hospital. All patients were screened for MRSA on initial admission to the hospital and re-admission after hospital stays. We saw in patients' medical notes documentation regarding these assessments. This meant colonisations were detected straight away and treated with 100% success rate.
- We saw the organisational audit summary presented to the clinical governance meeting in September 2016. Nursing audits included infection control and infection rate surveillance for level 1 in the main building (96%), special care unit (100%) and Tobias House (90%). The result of the audit for Tobias House was worse than the previous audit and highlighted areas which included further training and supervision of staff. This included hand wash basins were non-compliant with regulations, hand washing after removal of gloves and clinical waste. The cleaning audit for the art therapy department was compliant in all areas to ensure all items were clean and stored in a dust free environment. The infection control audit for the physiotherapy department scored 94%. The two non-compliant areas were inappropriate hand washing facilities and sharps bin not wall mounted.

Requires improvement

Long term conditions

- The National Specification for Cleanliness (NSC) provides guidance for hospital cleaning. Although there is no specific requirement to use the NSC there is a responsibility on the provider to have an appropriate system in place. NSC is seen as the minimum requirement unless risk assessments have been carried out which reflect local needs. We were shown the hospital's strategic and operational cleaning policy which provided clear guidelines and protocols for both individual patients and the environment to reduce the risk of infections. Additionally, how cleaning and monitoring would be carried out. Section 24.1 of the policy stated 'monitoring is key to ensuring standards of comfort and cleanliness remain high' and 24.2 'the hospital operates a robust monitoring system based on the NSC'. Moreover the policy showed the risk categories and the frequency of audits: high risk monthly, significant risk every three months and low risk every six months.
- However, we found there were no checklists or schedules being used as stated in the operational policy and as required by the NSC. We saw no evidence of an effective auditing system. We saw one audit dated October 2016 for Tobias House that had been undertaken with no overall percentage achieved and no evidence of further audits taking place. We saw nine areas had fallen below the standard and had failed. There was no evidence of any form of corrective actions relating to the areas that had fallen below the expected standard. We asked for a summary of the percentages of all the areas of the hospital and this was not provided. The audit stated a follow up audit was to occur in November 2016 and we saw no evidence this had been performed.
- Section 13 of the operational policy was titled 'cleaning schedules'. This section referred to the cleaning service, terminal cleans, service level agreements and daily cleaning. The section did not refer to any cleaning schedules, explaining when a task had to be done, by whom and with what equipment. However, we saw there were cleaning schedules for individual rooms and toilets, which were fully completed. Housekeeping staff showed us their cleaning schedules which clearly set out the tasks to be performed and their frequency. They were required to sign when each task was completed and their supervisor checked their work.
- Best practise guidance provided by the Department of Health, Health Building Notes (HBN's) gives comprehensive guidance on the design, installation and operation of specialised buildings and technology used in the delivery of healthcare. We found the hospital had not given consideration regarding this guidance for shower heads, carpets, wall surfaces, and waste.
- We saw three shower heads within the hydrotherapy area had scale present and were damaged. Health Technical memorandum (HTM) 04-01 states in section 3.185 'to minimise the possibility of bacterial colonisation of shower heads, they should be regularly cleaned and descaled'. We asked for the cleaning and descaling regime for shower heads. We were told this was the responsibility of both the estates and cleaning staff and was performed by 'whoever had the time'. None of the cleaning regimes were documented, so we were unable to see any evidence if the shower heads were cleaned or descaled. This meant there was a potential risk of bacteria colonisation on the shower head which would put immuno-compromised patients at risk.
- The hospital had a purpose built physiotherapy gym. Since our last inspection carpet had been removed in the gym and replaced with flooring, which was seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. This was in line with However, all patient bedrooms and corridors on the first floor ward had carpet, which was not in line with HBN 00-09. Whilst there is no requirement for independent healthcare providers to comply with the Department of Health building notes, it is advised that independent healthcare providers consider the guidance when planning services and undertaking building maintenance and risk assessments. Staff were not aware of a plan to remove these carpets. We asked for specific risk assessments regarding the carpeted areas as per HTM 00.09 and also general risk assessments of the cleaning tasks. We were told that every carpet was shampooed every five to seven days when they 'had time'. However we were not provided with evidence of this taking place.
- We found all the walls in the buildings to be covered in a textured surface coating. The walls were not smooth and the coating had been applied in such a way as to

be of a rough cast finish. This meant the cleaning of walls would be difficult and potentially harbouring bacteria in the rough surfaces. HBN 00-09 section 3.119 for wall finishes states: 'smooth cleanable impervious surfaces are recommended in clinical areas. Design should ensure that surfaces are easily accessed, will not be physically affected by detergents and disinfectants, and will dry quickly. Additional protection to the walls should be considered to guard against gouging/impacts with bedheads and trolleys. Wall surfaces should be maintained so that they are free from fissures and crevices'. The chief executive of the hospital told us they had sourced a product to be applied over the wall coatings to enable them to be easily cleaned. However, at the time of the inspection none of the walls in the hospital had this finish applied

- During the inspection we asked the estates staff if a specific risk assessment had been undertaken by a specialist as part of the water safety management regime. We were told that it had not. HTM 04-01 requires the provider to ensure samples are taken from hot water heaters annually in order to note the condition of the drain water. The provider informed us after the inspection the inspection team was misinformed by the member of staff regarding the availability of an external risk assessment. We were provided with the specific risk assessment which had been undertaken by a specialist as part of the water safety management regime. We saw the assessment was completed every two years and this was last achieved in May 2016.
- We checked the records for legionella testing. We saw records of temperature checking of approximately 232 outlets which were checked on a monthly basis. We specifically checked the records for January. We found all the temperatures recorded were for hot and cold water and were within an acceptable range for all areas except a female toilet and the hydropool area. These temperatures were recorded as 35°C. HTM 01-01 states: 'the required temperature for hot water to be a minimum 50°C and cold water to be below 20°C'. The provider informed us thermostatic mixing valves (TMV's) were installed directly into the outlets. TMV's are precision devices which blend hot and cold water together.
- The hospital's water system and usage policy covered hot and cold water, hydrotherapy pool testing for legionella and infections. Section 1.4 states 'all non conformances recommendations and actions taken are to be clearly documented on the monthly check list'. Section 1.5 of the policy also states: 'clear documentation of non compliance found (exceeding stipulated temperature or not reaching stipulated temperature)' and 'date non conformance was rectified and new test result'. In January there were two non conformancies and we saw no record of any descriptions recorded on the monthly check list .
- Further discrepancies were noted in water safety records and the provider did not follow their policy. Section 2.9 states 'record the temperature from the cold tap'. Data from the provider showed the temperature of hot sentinel taps (the first and last taps on a water distribution system) were recorded for all areas in January 2016 and the records for cold taps were left blank. Section 3.2 states 'the max temperature should be 43°C for wash hand basins'. The records showed the temperatures recorded were 60.7°C in special care unit room 6 and 60°C in bathrooms 1 and 2 in Tobias House. These were recorded as satisfactory by the provider. The hospitals policy section 3.6 states ' all temperature records must include the following – action taken and date action taken'. No actions were recorded.
- Best practise guidance HTM 04-01 requires 'little used outlets' (taps that are not used on a regular basis) to be flushed twice a week. The provider told us there were none and as the three water tanks were completely used every day flushing would not be necessary. Records showed us there were three outlets in the special care unit, and although not used would be classified as 'little used outlets' within the legislation. Therefore these should be flushed twice a week as legionella can stay in what is known as a dead leg of pipe work that would service these outlets and need to be flushed to remove any potential risk.
- HTM 04-01 requires the provider to ensure samples are taken from hot water heaters annually in order to note the condition of the drain water. Additionally it requires a monthly check of temperatures in flow and return of water heaters and a six monthly check of the temperature of the water entering the building to be

below 20°C and visually inspect cold water storage tanks and to carry out remedial work where necessary. We were shown no records of the above points which showed there was not an appropriate water safety management regime in place which could lead to the water being potentially unsafe. Therefore, we found the hospital was in breach of Regulation 12: Safe care and treatment for water safety.

- The results of the patient satisfaction questionnaire, August 2016 showed 72% of patients rated the hospital as clean. This was an improvement from the last survey and nearly all responses stated hand gels were full and available for use.
- After this inspection the provider had introduced the patient led review of care environment devised using the NHS national assessments framework. We saw the results summary report which represented the views and comments of 20 patients, their carers and visitors from February 2017. The average score for all areas was good. The provider told us the results were to be used as a benchmark from which improvements could be made and higher standards attained. The introduction to the report stated the results were presented with a conclusion with which an action plan had been devised. We did not see the action plan.
- Contrary to the above, all the areas we visited in the hospital were visibly clean and tidy. All areas inspected were of a standard that would align with their risk category in the NSC. All areas inspected on this inspection were cleaner than the last inspection and therefore the cleaning regime appeared to be satisfactory. We were told by the domestic staff that following our last visit two more housekeeping staff had been employed which had helped maintain standards. However, we found there remained a lack of understanding by the provider as to their responsibilities and the importance regarding the processes behind the cleaning system. We were told the chief executive managed the cleaning and the director of nursing had overall responsibility for infection control. A hotel services manager had been employed and was in training for the role. Once completed they would be implementing these processes and the responsibility for infection control would be passed to them.
- During the inspection we saw staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the WHO guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, in line with best practise guidelines Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information was displayed demonstrating the appropriate hand washing technique
- Hand-sanitising gel was available at point of care in all patients' rooms and throughout all areas of the hospital. This was in line with . We saw staff using hand sanitiser when entering and exiting clinical areas.
- We saw personal protective equipment was available for all staff and observed staff use it appropriately.
- Disinfectant wipes were available in clinical areas. Equipment which was shared between patients, for example hoists and observation equipment, was cleaned with these between each patient use. We observed staff doing this. A checklist was attached to each piece of equipment and staff indicated on the checklist, when equipment had been cleaned, between each patient use. We saw this was being completed.
- Treatment couches in the physiotherapy department were covered with a wipeable fabric. The fabric on every piece of equipment we checked was intact. This was in line with Hospital Building Note (HBN) 00-09,which states: Soft furnishings (for example, seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam-free or heat-sealed.
- We checked four mattresses and two pressure cushions across the hospital. All were unzipped and we found them to be clean with no stains or offensive smells.
- Waste in the bedrooms and clinical areas were separated and in different coloured bags to identify

the different categories of waste. This was in accordance with Control of Substances Hazardous to Health (COSHH)and Health and Safety at Work regulations.

- All patients wore their own clothes. The hospital washed patients' clothes regularly and staff told us they put soiled items of clothing into a red bag and sent it to the laundry room. This was line with best practise HTM 01-04.
- All patients who required hoisting were assessed for individual slings before admission. Each patient had their own slings assigned to them and these were kept in their individual bedrooms. Staff explained to us the process if a sling became soiled. This was placed in a red bag, sent to laundry and returned to the individual patient.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the temporary closure mechanism was engaged. We saw the labels on sharps bins had been fully completed which ensured traceability of each container. A poster advising staff of what to do in the event of a needle stick injury was positioned by every sharps bin that we saw.
- We reviewed the strategic cleaning plan 2016 to 2020. Section 3.2 states 'the hospital will ensure its premises and facilities are maintained in a condition conducive to cleaning' and section 3.3 states 'promote cleanliness throughout the hospital in order to deliver effective cleaning services, ensuring the hospital complies with the Code of Practice for the prevention and control of HCAI's cleaning element'. The governance section (section 4) states 'final accountability for all aspects lies with the chief executive and the delivery of the cleaning strategy will be monitored by the IPC lead'. Additionally three monthly reports to be issued to the chief executive and half yearly summaries available to the CCG.

Environment and equipment

- Best practise guidelines issued by the Department of Health, Health Building Notes (HBN's) gives comprehensive guidance on the design, installation and operation of specialised building and technology used in the delivery of healthcare. We found the hospital was not in giving consideration regarding this guidance for waste management. We inspected the clinical waste compound and found the clinical waste section unlocked on both days despite bringing this to the attention of the health and safety manager and the estates manager. Within the compound two of the eight bins were unlocked on the first day of our inspection. On the second day three out of the eight bins were unlocked, and one bin was over spilling. This could lead to vermin infestation which was possible given the location of the site. As some bins were open, unlocked and/or over spilling there was potential access to the general public. This meant hazardous waste was available to the public which potentially could cause harm.
- At our last inspection we told the provider they must ensure all fire exits had appropriate fire exit signage. The provider told us this work had been completed. At this inspection we found in the main building there were exits at either end of the corridors marked with fire exit signs. There were also directional signs commonly known as 'green running man signs' at the fire exit.
- At our last inspection we told the provider they must ensure the fire exit from the physiotherapy room is wheelchair accessible. The provider told us this work had been completed. At this inspection we found a ramp had been provided. However, this led onto an area by a large tree. The land was uneven and had tree roots and mud along the route of escape. We were told that the route had been tested.
- The hospital had been subject to an external review in the last 12 months for ISO 9001 Quality Management Systems, ISO22000 Food Safety Management, ISO 14001 Environment Management Systems and ISO 18001 Occupational Health and Safety Systems. They had also received Investors in People, United Kingdom Commission for Employment and Skills 2013.
- We saw there were processes in place for regular equipment checks both from internal and external maintenance sources and a clear preventative maintenance process.

- We saw equipment service records which indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw electrical testing stickers on equipment, for example adapted baths and hoists, which indicated the equipment was safe to use.
- We inspected 26 hoists (six overhead, 14 mobile, five bath and one pool hoist). Maintenance records showed the hoists were inspected every six months by a specialist company. One hoist was recorded as unsafe and we saw it had been locked into an inoperative state by the maintenance company to prevent its use. This could only be unlocked by the company when it was repaired so it was kept safe until repaired.
- Managers assessed staff to ensure competency before they used any medical devices, for example nebuliser, We saw examples of competency assessments in staff records, which were kept in ward areas.
- Staff told us since the last inspection "there have been lots of change and only good things have happened". They explained although previously they had been checking the equipment this was not documented. They could explain why this was important. We observed records which showed staff checked equipment daily for defects. These included tracheostomy equipment, suction machines, nebuliser, beds, pulse oximetry, wheelchairs, thermometer and commode. All equipment was operational and quality controlled. Staff told us if they experienced any problems this was actioned and reported to the health and safety officer.
- Staff reported no problems with equipment and felt they had enough equipment to run the service. We were told there were no issues around securing the necessary equipment for individual patients, for example pressure relieving mattresses and hoists. The mattresses used by the hospital were fit for purpose and provided protection from infection and pressure damage.
- Emergency equipment was located in the main building and Tobias House. The resuscitation trolley in Tobias House contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We saw the trolley was secure and fully stocked and ready for immediate use. All equipment needed was available, as indicated by an equipment list. All consumables were in date. There was a system for checking these every Monday and Friday and we saw the fully completed records of checks.
- The emergency bag was kept in the nurse's office on level 1 of the main building. Staff told us they knew where the equipment was kept and had access. The emergency bag contained all relevant equipment including in date medication, oxygen and a defibrillator which was charged and ready for use. The bag was checked twice weekly and records showed this was up to date.
- Some patients were admitted to the hospital with their own wheelchair. Patients were responsible for the servicing of wheelchairs and the hospital monitored this and had assurances. The hospital had spare wheelchairs for transport.

Medicines

- A medicines policy was in place, had been reviewed and had a date for future review. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs. We observed the administration of medicines met the guidance issued by the Nursing and Midwifery Council standards of medicines management 2015. We observed processes were in place to ensure medicines were administered as prescribed in a timely manner and were available when needed. Waste medicines were disposed of correctly.
- The hospital had an accountable controlled drugs officer (CDAO). The CDAO is responsible for establishing, operating and reviewing the appropriate arrangements for safe management and use of CD's (medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription and administration). Controlled drug audits were completed every three months to help monitor this. We saw on the wards we visited two members of qualified staff completed CD checks daily. We saw CD stock books were completed to record the

checks and were signed and witnessed throughout books. Spot checks on balances during the inspection showed contents of the cupboards matched the registers.

- We saw the organisational audit summary presented to the clinical governance meeting in September 2016. Medication was audited in level 1 main building (92%), special care unit (100%) and Tobias House (98%). This looked at medicine use, prescriptions, storage, disposal and safety. Areas highlighted with action plans were for staff to document in correct colour ink, recording allergy status, the route and rate of administration and expiry date of medicines, and documenting delivery of medicines.
- Medicines were stored securely to minimise unauthorised access. We saw medicine cupboards, fridges and trolleys were locked. The nurse in charge on the wards held the keys and only authorised staff had access to the keys. We saw the doors were secure and locked.
- We saw medicines trolleys and fridges were clean and tidy. We found all the items stored were within date and there was a system of expiry date checks by staff.
- Some medicines were required to be kept refrigerated, for example insulin. The hospital's policy states: 'medicines stored in the fridge must be kept at a temperature of between 4 and 6°C and checked daily for temperature control and cleanliness'. We saw records showed regular recording as per the policy for minimum and maximum temperatures. We saw the medicine fridge on level 2 ward in the main building, staff recorded temperatures daily with no breaches. Staff explained they would contact maintenance if there were discrepancies. However, the fridge on level 1 ward of the main building showed recordings below 4°C on five occasions between 17 January and 6 February 2017. No action taken was evident and this could impact on the safety and efficacy of medicines.
- We saw ambient room temperatures in medication storage rooms were checked and recorded daily. These were within the acceptable range (18-25 °C).
- We observed the appropriate storage of oxygen cylinders as part of the emergency medicines. We also saw larger oxygen cylinders were stored in appropriate holders.
- The hospital had a service level agreement with a local pharmacy who reviewed patients' medication. The pharmacy audited and advised to ensure medications were clinically appropriate and to optimise outcomes.
- Medicines were ordered from a local chemist in a 28 day cycle period. Medicines were supplied in original packs. Reception staff checked the delivery and stored in a locked cupboard. Allocated nursing staff collected the medicines and signed the delivery note to indicate they had done so. We saw a signed delivery note, which indicated this was occurring. There were arrangements for staff to obtain medicines when these were required urgently.
- We observed good documentation of patient's allergy status and microbiology consultation. These were observed both in the patient's multidisciplinary records and medicine administration records (MARs).
- We observed the records of administration. The prescription charts of 13 patients were reviewed. We saw evidence of regular medical support to the wards and regular documented reviews of patients' medicines. We saw records of changes which had been made to patient's prescriptions and clear records of the monitoring required with some medicines. The hospital had recently introduced a 'when required medication' log to record when people were given these medicines. This meant staff could tell when the last dose was given and when it would be safe to give the next dose if needed.
- The hospital had a process in place to competency assess staff to ensure they were able to administer medicines safely. We saw examples of competency assessments that had been undertaken for two staff.
- Staff we spoke with told us they knew to obtain advice from the pharmacist or doctor before administering covert medicines. Covert is the term used when medicines are crushed and administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. At the time of inspection there were no patients receiving covert medication.
- We saw individualised protocols in place for seizure management for some patients. These protocols were

kept in the patients' multidisciplinary records. Appropriate medicines were administered by registered nurses and we saw records of the administration of this medicine.

- The hospital had a Patient Group Direction (PGD) for the administration of medicines for a suspected urinary tract infection (UTI). PGD's are written instructions to authorise appropriate personnel to administer medicines in planned circumstances. The PGD was used appropriately by staff. We saw the PGD was signed by a doctor and kept in their office.
- We saw an alert system could be quickly cascaded through the hospital to ensure they were working within the national framework for the Medicines and Healthcare Products Regulatory Agency (MHRA). This is responsible for ensuring that medicines and medical devices work and are safe. The ward managers checked the list of alerts against medicines on the ward and disposed of any relevant medicines. We saw level 1 ward in the main building kept a record of disposed medication.
- We saw appropriate arrangements were in place for people to take their medicines with them if they were on leave from the hospital for example outings and visits to acute hospitals.
- Information about medicines administration errors was recorded, and we saw some evidence of shared learning communicated at handovers and through training sessions, to reduce the risk of reoccurrences. We also saw examples of staff supervision in response to medicines administration errors.

Records

- We saw patient records were stored in locked cupboards and kept securely at the staff stations, which were in constant sight of staff. This maintained security and prevented unauthorised access of patient records.
- Across the hospital we observed a total of 20 records. We found these were comprehensive, contemporaneous and reflected the care and treatment patients received. We saw records were well maintained and easy to navigate. They were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. Patient records were readily accessible to those who needed them.
- Patients' records were multidisciplinary and doctors (including those with practicing privileges), nurses and therapists contributed to a single unified document. This ensured relevant information was not omitted and that the entry was easy to follow and understand. Each patient also had bed side notes which were completed and transferred with the patient when they attended treatments. We saw these notes were transferred to the full patient record on a daily basis.
- We saw all members of the multidisciplinary team recorded in a specific section in the patient notes. We saw records written by the psychiatrist, medical staff and the dietician. Patients had a comprehensive pre-assessment prior to patients moving into the service. We saw staff completed the pre assessment records appropriately including risk assessments and care plans were in place. These included detailed medical, nursing, therapists' input, and goals.
- We saw therapists had recorded all interventions which were recorded comprehensively with reference to subjective, objective, assessment and plan (SOAP) guidelines. They defined the patient's goals with evaluation and had consent and best interest decision documented.
- The British Society of Rehabilitation Medicine (BSRM) recommends standards of best practice for care for patients with a complex neurological disability. Each patient should have a timed set of outcome goals that involve their family and are coordinated by the multidisciplinary team. The goals should be reviewed at a frequency appropriate to the patient's management and be combined with suitable outcome measures.
- Each patient had a six weekly meeting to evaluate and decide future goals. Patients and their families set individual goals with their therapists and this was recorded as an action plan in the patient notes. The individual goals included attending mindfulness sessions, engagement in functional tasks such as cooking and attending the relaxation group.

- We saw patients in the special care unit had a separate record which could be taken with the patient when they left the unit on an escorted visit. This contained risk assessments including food and fluid protocol, seizure procedure, mobility, allergies, medication and contact information.
- We saw records contained useful photographs for positioning and posture of patients for both bed and chairs. We noted when risks were identified relevant care plans which included control measures were generated. We saw risk assessments were reviewed and repeated within appropriate and recommended timescales.
- We observed patients with a tracheostomy had a tracheostomy passport. This complied with the national initiative introduced for standards and guidelines for tracheostomy care by the Intensive Care Society. This ensures consistency in practice as patients move between home and hospital.
- We saw the organisational audit summary for therapists and nursing staff presented to the clinical governance meeting in September 2016. Nursing staff audits included care planning, clinical documentation, nursing assessment and admission checklist for level 1 in main building, special care unit and Tobias House. Generally the audits showed an improvement since the previous audit and highlighted areas for improvement. This included the provision of training in regards to error corrections and legible entries.
- We reviewed the therapists' audit and found the case note audit showed all were generally compliant. The documentation audit for occupational therapy showed partial compliance and staff were reminded to use the goals database and ensure all goals were documented and therapists to update and review protocols more frequently. The physiotherapy department reviewed documentation against 31 criteria and 26 of these were compliant. Areas which required action included assessments for Modified Ashworth Scale (measure of muscle spasticity in patients with neurological conditions), range of motion and splinting risk, ensuring the patient's name was printed on every page and ensuring all SOAP were completed.
- The ward managers for level 1 and level 2 in the main building showed us the completed clinical audits every three months. We saw ten patient notes were audited against eight areas including admission checklist, infection rate surveillance, medication and nursing assessment. The report contained findings, recommendations, areas of non-compliance and percentage of compliance. This enabled the hospital to make comparisons between the two wards and see changes in compliance. However, there were no hospital targets for compliance therefore staff could not identify areas of success or for improvement easily.
- Of the 20 records we looked at, we reviewed five archived records. These were all comprehensive records except one record contained another patient's information. This included timetables, patient property list, pathology request form, ABC charts and a death medical certificate. We highlighted this to the provider at the time of the inspection and this was actioned immediately.

Assessing and monitoring risks to people who use services

Responding to patient risk

- At our last inspection we told the provider they should consider how an early warning system such as the National Early Warning Score (NEWS) could be used to comply with BSRM guidance. NEWS was introduced by the Royal College of Physicians and is a tool used by medical services to quickly determine the degree of illness of a patient. At this inspection we found the hospital had introduced the NEWS chart and we saw these were fully completed in patients' notes. We saw evidence of escalation, when clinically indicated in line with the NEWS guidance. This showed the level of care the patient would receive if they became unwell for example ward based care, transfer to the local hospital or end of life care. We saw staff documented discussion of decisions with the patient and their families.
- We saw patients were risk assessed in key safety areas using nationally validated tools. For example, we saw the risk of malnutrition was assessed using the malnutrition universal screening tool (MUST) and the risk of pressure damage was assessed using the

Waterlow scoring tool. MRSA screening, pain score, bedrails and falls assessments were completed. However, staff did not complete risk assessments as often as required and incorrectly calculated some scores.

- Staff completed nursing observations sheets. The nurse assessed the current patient risk, decided the frequency of observation, and documented the rationale for this. Staff would check on the patient's wellbeing and document their needs such as repositioning or pain relief. We reviewed 25 entries and found eight were illegible.
- The organisational audit summary, September 2016 contained the chest infection audit (for individuals with tracheostomies and/or are at high risk of respiratory problems) for all areas of the hospital. The aim of the audit was to ensure the delivery of chest physiotherapy for relevant patients. The results of the audit showed all areas were compliant and infections were actively managed.
- We saw an alert system that could be quickly cascaded through the hospital to ensure people were working within the national framework for the Medicines and Healthcare Products Regulatory Agency (MHRA). This is responsible for ensuring that medicines and medical devices work and are acceptably safe.
- We saw level 1 ward in the main building kept a falls register in the nurse's office. Staff completed this after every patient fall and included details of fall, interventions and staff signature. Additionally the ward kept an infection register folder. Staff completed a form for each patient infection. The form included symptoms and site, date of onset, type of specimen sent, laboratory result and treatment. The registered nurse discussed this with the doctor and signed the form. We saw three completed forms one for MRSA and two for urinary infections.
- We saw four completed tissue viability reports. The tissue viability link nurse completed a report for all departments every three months. The report included a summary of each department and then a detailed review of patients with a skin related issue such as post-operative wounds or a pressure ulcer.
- We saw risk assessments for each patient who attended oil immersion therapy. The therapists monitored and observed the patient's vital signs (blood pressure, auxiliary temperature, pulse and respirations) and these were recorded in the patient's bed side notes which accompanied them to the therapy room. Observations were taken again as treatment started and post treatment. These were all recorded. Actions to mitigate risk were documented.
- Emergency call bells were available in the therapy rooms and the physiotherapy gymnasium. Staff explained to us how to activate the alarm and gave us examples of times this had been used. They told us the response from bleep holders was rapid.
- All staff received training in basic life support and anaphylaxis. All medical practitioners undertook advance life support training, immediate life support training was for all registered staff and non-registered staff completed basic life support. This face to face training was part of induction and staff attended an update every year. We saw mandatory training records which showed us all appropriate staff had completed the training.
- The hospital did not have facilities for an acutely ill patient and they would be transferred to a local NHS trust.

Nurse staffing

- Nursing staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long Term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.
- We saw the off duty for nursing staff for January and February 2017. The actual number of staff working matched with the agreed number recorded on the off duty.
- Staff told us nurse staffing levels were reviewed in line with patient acuity and this process started at the pre-admission assessment of a referral. This was reviewed at the case presentation every three months or sooner if required. For example if a patient required

one to one nursing support, the staffing would be increased if providing such a service would be detrimental to existing staff levels. During our inspection, level 1 ward in the main building had three patients requiring one to one nursing care and the planned staffing rota reflected this.

- Level 1 ward in the main building had 22 patients. The off duty showed there was one ward manager, two qualified nurses and 12 rehabilitation assistants on a day shift and one qualified and five assistants at night.
- Level 2 ward in the main building had nine patients. The off duty showed there was one manager, one qualified nurse and five rehabilitation assistants on the day shift and one qualified and two assistants at night.
- The special care unit had eight patients. The off duty showed there was one qualified mental health nurse and four rehabilitation assistants on the day shift and one qualified and two assistants at night.
- Tobias House had nine patients. The off duty showed there was one qualified nurse and five rehabilitation assistants on the day shift and one qualified and two assistants at night.
- The hospital employed 30 full time and four part time qualified nurses. In addition to this, they employed 84 full time and one part time rehabilitation assistants.
- Full time qualified nurses and rehabilitation assistants were contracted to work a 42 hour week. They worked a 12 hour shift and during a week they were rostered to work three long days and one half day.
- Each patient was assigned two key workers who worked opposite shifts (day/night) to provide continuity for patients. Every Wednesday afternoon the off duty allowed the two key workers to work together to enable them to handover about their specific patients. This was also an opportunity for staff training.
- We saw there were two handovers for staff every day. These were between 7.30am and 8am and 8pm to 8.30pm. Staff in Level 1 ward in the main building and Tobias House showed us copies of the written records of handover, which were kept in folders in the nurse's office. The handover was comprehensive, used a template and included topics such as current status, vital signs, fluid balance, pressure areas, feeding requirements, infection and repositioning.
- The majority of staff recruited by the hospital were from overseas countries where they had practised as registered nurses. They started as support workers at the hospital and when they acquired their Nursing and Midwifery Council (NMC) registration they were able to practice as registered nurses.
- Information provided by the hospital showed in the three months prior to inspection, 34 shifts were covered by qualified nurses and 26 shifts by rehabilitation assistants as bank staff. During the same period, no shifts were covered by agency qualified nurses and 637 shifts by agency rehabilitation assistants. In January 2017 the hospital had 14 full time equivalent vacancies (one directly employed doctor, two nurses, one therapist and 10 rehabilitation assistants).
- We saw the hospital received assurances from the agency used for staff. This included training, qualifications, disclosure and barring service (DBS) check, immigration status, and details of induction. Staff in Tobias House told us they would use the same agency staff who were familiar with the hospital to provide continuity.

Allied Health Professionals

- The hospital had a large therapy team which included physiotherapists, occupational therapists, psychologists, speech and language therapists, art therapists, music therapists, drama therapist, eurhythmy and external application therapists. Therapist staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long Term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.
- The provider told us therapist staffing levels were regularly reviewed in line with patient acuity. At the time of inspection the hospital employed 35 full time equivalent therapists and allied health professionals.

Long term conditions

Support staff

- Support workers at the hospital included administration, domestic, estates and kitchen staff. The hospital did not provide us with data of how many support staff were employed.

Medical staffing

- Medical staffing levels adhered to the recommendations as defined by national guidelines including the BSRM, the National Service Frameworks for Long Term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.
- The provider told us all patients were under the care of a consultant for their relevant conditions. Consultants for psychiatry, rehabilitation medicine and neuropsychiatry worked at the hospital.
- The hospital directly employed one full time doctor and six part time doctors under rules of practising privileges. Information provided by the hospital showed in the three months prior to inspection, 34 shifts were covered by a regular agency doctor. Staff told us the medical cover at the hospital had improved. They were able to see more patients each day and each patient was seen by a doctor at least once a week.

Anticipation and planning for potential risks

- We saw all patients had a personal emergency plan in their records which complied with the regulatory reform (fire safety) order. It identified what support the patient would need in the event of a fire such as one to one care. Additionally this explained the arrangements of how to transport the patient in the event of an emergency situation.
- Records showed us staff practiced emergency scenarios monthly in different parts of the hospital. Staff told us they received feedback following the scenario on what went well and what required improvement.
- Documentation showed us staff practiced a hydrotherapy emergency evacuation procedure every two months which was in line with best practice.
- The hospital provided us with their 'threat analysis – identified threats' policy. The policy described 17 human and 14 non-human dimensions of a disaster with damage caused and solution listed for each. The plan identified the threats but did not advise on what staff were actually to do in the event of a disaster. The mitigating actions (titled solutions in the document) were not explicit in the preventative actions staff should take, nor did they explain clearly actions staff should take should one of the identified threats become a reality. For example, the damage caused by the identified threat plumbing stated 'damage to furniture and furnishings, equipment, computers, rooms would have to be closed, new locations found for affected patients'. The solution stated 'ensure that all plumbing is carried out properly and any damp patches on walls, ceilings or floors must be investigated immediately'. There was no categorisation of the severity of the risk based on its likelihood or potential impact recorded.

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

Good

We rated effective as good.

Evidence-based care and treatment

- The provider told us it regularly reviewed the service it provided in line with British Society of Rehabilitation Medicine (BSRM) Guidelines, National Service Framework for Long Term Conditions, The Royal College of Physician Guidelines for Acquired Brain Injury and Prolonged Disorders of Consciousness (PDOC), Specialised Services National Definitions Set (SSNDS) and National Institute for Health and Care Excellence (NICE) guidance.
- The hospital delivered care in line with BSRM guidance. They ensured all patients with a disabling illness or injury were assessed by a consultant in rehabilitation medicine or their designated deputy in line with NHS England and BSRM's framework.
- All patients had their needs assessed on admission and all relevant care plans, risk assessments and

protocols were put into place within the time frame specified by BSRM guidelines. A checklist was available within the care plan to ensure these were done in a timely manner.

- We saw the hospital had incorporated the quality requirements of the National Service Framework for Long Term Conditions. It provided a person centred service, community rehabilitation and support, vocational rehabilitation, and provided equipment and accommodation to support them to live independently.
- We saw the hospital had developed their service for patients who were in altered states of consciousness in line with the Royal College of Physicians Guidelines for people with PDOC. They utilised the recommended structured assessment tools to aid accurate diagnosis and to monitor patients. For example they used the Wessex Head Injury Matrix (WHIM) and the JFK Coma Recovery Scale. The provider ensured all patients were provided with appropriate diagnosis and we were told they would seek further opinions if required.
- The hospital used the Care Programme Approach (CPA) for patients with mental health problems or a range of related complex needs. We saw care planning was in line with the Mental Health Act and the Mental Capacity Act Code of Practice. We saw the minutes of a CPA meeting dated September 2016. The occupational therapist, nurse in charge, clinical commissioning group, the patient and their relatives attended the meeting. This demonstrated service users and their relatives are involved in care planning.
- We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework. Staff were able to access national and local guidelines through the internal computer system. This was readily available to all staff. Staff demonstrated how they could access the system to look for current hospital guidelines. We noted there were appropriate links in place to access national guidelines if needed.
- We saw level 1 ward of the main building kept a tracheostomy folder, which contained the hospital's tracheostomy guidelines (review 2018). We saw staff signed a list to say they had read the guidance. Additionally the ward kept a national framework folder which contained the Department of Health (2008) 'National Service Framework for long term neurological conditions' and 'National Standards, location action, health and social care standards and planning framework 2005/6-2007/8'.
- Level 1 ward of the main building kept a resuscitation folder which contained the hospital's resuscitation policy. We saw all staff signed a list to say they had read the policy. However, the resuscitation folder contained an out of date policy for Do Not Attempt Resuscitation and an out of date Resuscitation Council UK Guidelines (dated 2010). The Resuscitation Council UK published new guidelines in 2015; this meant staff might not follow the latest evidence based guidance.
- We saw the plan for clinical audit frequency for 2016. Each audit was to take place every three months in January, April, July and November. Subjects covered were admission checklist, care planning, clinical documentation, controlled drug, infection control, infection surveillance, medical emergency report, medication and nursing assessment. We saw the organisational audit summary was presented to the clinical governance meeting in September 2016. This included audits specific to therapists for case notes, cleaning, documentation, chest infection audit, infection control, botox, and health and safety. Nursing audits included admissions checklist, care planning, documentation, infection control, infection rate surveillance, medical emergency, medication, nursing assessment and 'do not attempt cardio-pulmonary resuscitation' (DNACPR).
- The non-clinical audit frequency plan for 2016 showed audits should take place every three months in February, May, September and December. The types of audit were health and safety and preventative maintenance and hazard analysis critical control point (HACCP). The plan stated the audits were to be submitted to the clinical governance meeting. We saw the organisational audit summary presented to the clinical governance meeting in September 2016. The health and safety audit showed three issues had been achieved since the audit in May 2016. The three remaining issues were: two hoists inoperable in the gym, storage space required for unused equipment and no thermometer available in the gym.

- The provider told us the organisational and audit summary was a pilot as part of a proposed modernisation of the audit programme and audit cycle to be circulated annually. The provider was currently in the process of redesigning the entire audit programme including redesign of the audit reports, the development of the bi-annual 'quality improvement reports' and a more uniform approach to the process of conducting audits, frequencies and areas that required regular audit for the purposes of quality improvement and performance management

Nutrition and hydration

- NICE Guidance CG32 (2006) Nutrition support for adults: oral nutrition support, enteral feeding and parenteral nutrition advises on best practice for the care of adults who are malnourished or at risk of malnutrition. Using the Malnutrition Universal Screening Tool (MUST), helps identify those at risk of malnutrition, as well as those who are obese (too much body fat). It has five steps that give a score to indicate level of need and inform a plan.
- We saw staff assessed service users using MUST on admission and documented this on the MUST score chart. On the reverse of this was an illustrated flowchart demonstrating the action plans for low, medium or high risk groups. This was in line with the British Association for Parenteral and Enteral Nutrition (BAPEN) guidance. However, we saw staff did not follow this flowchart correctly. For example, service users were not reassessed weekly and a patient who scored two was incorrectly identified as medium risk when the flowchart showed a score of two or more indicated high risk.
- Staff assessed service users' nutritional requirements as part of the hospital's pre admission assessment tool and then monthly during admission. Although we saw documentation of completed nutritional requirements for service users, there were no action plans following the outcome. Therefore, it was unclear if staff took action following the assessment.
- The provider told us in keeping with their anthroposophical ethos, all foods chosen where possible were organic, freshly prepared and free from additives. The chefs worked with the dietician and speech and language therapist (SALT) team to provide suitable menus in keeping with the standards required.
- We saw documentation that showed a SALT assessment was completed for patients where appropriate. We saw the SALT had written an eight-week programme for a patient and documented their short and long-term goals.
- We saw the dietician assessed and reviewed service users including those with enteral feeding and documented in their care plan any changes to meal plans or feed prescriptions. We saw staff completed fluid and food charts for patients upon advice from the dietician.

Pain relief

- We saw the organisational audit summary presented to the clinical governance meeting in September 2016. The audit showed the physiotherapy department reviewed the effectiveness of Botox treatment in reducing patient pain incurred while splinting, during personal care or as a result of not engaging in therapies. Data was collected using the Abbey Pain Scale (the assessment of pain in patients who are unable to clearly articulate their needs). The results of the audit showed four out of six patients demonstrated significant reductions in pain.
- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) which states all in-patients with acute pain must have regular pain assessments using consistent and validated tools, with results recorded with other vital signs. Generally we saw staff completed pain assessment tools for patients. We reviewed the nursing handover sheets, which were stored in the nurse's office. We saw evidence that staff discussed any patients who had experienced pain, the actions taken and their effectiveness.

Monitoring outcomes

Patient outcomes

- We saw the hospital audited patient outcomes via a number of processes. Using a goal setting approach to patient's rehabilitation, the regular multidisciplinary team review played a significant part in auditing a

patient's outcome to given therapies. Outcome was reviewed using individual standardised measures, for example WHIM was used in auditing outcome in PDOC.

- The hospital used the Functional Independence Measure (FIM) and the Functional Assessment Measure (FAM) in auditing functional changes.
- The hospital also used the Rehabilitation Complexity Scale to audit changes in the level of patient need. We saw evidence of this documented as part of the patient's admission.
- Other assessments used to measure patient outcomes included range of motion assessments, the JFK coma recovery scale and the scale for the assessment and rating of ataxia (SARA).
- The United Kingdom Specialist Rehabilitation Outcomes Collaborative (UKROC) developed a national database collating all specialist neuro-rehabilitation services (level 1 and 2) across the UK. It provides information on rehabilitation requirements, the inputs provided to meet them, outcomes and cost benefits of rehabilitation for patients with different levels of needs. In collaboration with the BSRM it is a payment by results improvement project. It provides information on case mix and episode costs to inform the development of complexity weighted tariffs. Units using this flexible tariff must be registered with UKROC and report serial data and demonstrate that they are able to provide inputs commensurate with patient's needs.
- At the time of inspection the hospital told us that they has 22 level one and nine level two patients and they submitted data to UKROC for level 1, 2a and 2b patients. Staff told us the ward manager submitted data to the UKROC fortnightly using software on the hospital's computer. The ward manager printed the submitted scores and kept this in a folder in the nurse's office. Hospital administration staff could overview the hospital's submissions and reminded departments of deadlines. We saw a folder containing completed UKROC scores in the nurse's office. We saw the ward manager had submitted data for four patients in February 2017.
- Staff assessed patients to ascertain the level of service they required and the complexity of their needs using BSRM guidance. The staff reassessed patients at appropriate intervals to identify any changes in their needs, and their care plan was adjusted accordingly.
- Formal service reviews were carried out during Medical Advisory Committee (MAC) meetings and clinical governance meetings. Reviews around individual patient's needs were held during case review meetings. We reviewed MAC meeting minutes and found review of therapies was a standard agenda item.
- Every patient had individual patient outcomes. These were not collated collectively but mapped in case reviews and for goal settings. At case review meetings the multidisciplinary team, commissioners, social services, patients and their families discussed the patient's goals and outcomes to given therapies. Treatment was assessed for effectiveness and recommendations made.
- The therapy teams audited patient outcomes by using a goal setting approach to each patient's rehabilitation. We saw every patient had an individual goals action plan in his or her medical notes. The multidisciplinary team discussed and reviewed these goals at internal team meetings.

Skilled, knowledgeable, competent staff

- Staff in the hospital had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff professional registrations were due and to ensure they were renewed. These were demonstrated to us.
- We saw the hospital had a clear induction process. Staff we spoke with said they received a three-week induction. Managers allocated new staff to an experienced member of staff for support and supervision. Therapies staff told us they had the opportunity to shadow staff in other therapies to help them to understand everyone's role and responsibilities. Staff told us they felt confident at the end of the induction to work independently and always asked other staff for advice if needed.
- The hospital had competency assessment frameworks for each staff group. We looked at three staff records

on level 1 ward in the main building, which showed all three staff had completed the relevant competency assessment for their role. The competency assessment framework covered multiple topics including patient care, infection control, tracheostomy management, breathing, nutrition, artificial nutrition, bed positioning, splints, use of wheelchairs and mobility.

- We saw some registered nurses were rostered as supervised on the off duty. Staff told us either the ward manager or the team leader supervised registered nurses who had not completed their competencies.
- Staff told us they had access to local and national training. This contributed to maintaining their registration with their healthcare professional council. Managers encouraged staff to request additional training relevant to their role. The hospital funded additional training. For example, staff could attend the verification of death course.
- The provider encouraged staff to apply for study leave to attend courses, which would be of benefit to the patients, the hospital and individual staff. Staff disseminated their learning from any training to the rest of the team on their return at the weekly multidisciplinary meetings. We saw staff planned to attend a specialist course in May 2017 and two nurses and three therapists were booked to attend the brain injury conference in April 2017.
- One nurse told us they had found an external three day tracheostomy and ventilation training course which they wanted to attend. The hospital encouraged the nurse to attend the course. This demonstrated the hospital valued staff continuous professional development.
- Staff could access internal training. For example, the ward manager, who was also the lead for tracheostomy patients, provided tracheostomy care training on site. Staff also had access to revalidation training provided by the Royal College of Nursing.
- We saw a record for a rehabilitation assistant, which included completed training, competencies and an induction booklet. The record included supervised practice, medicines competency, supervision and other competencies. Staff told us rehabilitation assistants could access training in (PEG) feeding and in Tobias House trained rehabilitation assistants would care for patients with PEG feeding.
- All staff working at the hospital had received an appraisal in the last year and we saw records, which confirmed this. Staff we spoke with felt the appraisal was a good way of celebrating work they had achieved and identifying learning opportunities. We saw completed appraisal forms which showed individual objectives, goal setting with timeframe and who was responsible for actions.
- Staff told us they received clinical supervision. Staff in the special care unit received three monthly supervision and staff on level 1 ward in the main building received monthly clinical supervision. Staff felt this was sufficient and felt well supported.
- We saw records, which showed 11 out of 22 members of staff had received supervision on level 1 ward in the main building. Issues raised during supervision included how to recognise a near miss, identifying areas for staff improvement such as record keeping and listening to others to support team working.
- Nursing staff and rehabilitation assistants worked long days and nights, except for Wednesdays when staff worked an early or late shift during the day to allow for staff training at 14.30 to 15.30. Reception kept the attendance list of this training.
- We saw the hospital received assurances from the agency used for staff. This included training, qualifications, disclosure and barring service disclosure and barring service (DBS) check, immigration status, professional registration and details of induction. Agency staff were regular staff who were familiar with the hospital and its ethos.
- All medical staff had completed sepsis training. The provider told us they were in the process of providing this training for all staff and this was to be part of the mandatory training matrix. We saw the arranged training dates for February and March 2017. The aim was for all staff to have attended this training by the end of March 2017. NHS England's guidance on improving outcomes for patients with sepsis (cross system action planning) had been made available for all staff.

- Six doctors worked under practising privileges agreements. The granting of practising privileges is a well-established process within independent healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice. We saw the evidence the provider had complied with legal duty to ensure regulation 19 in respect of staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw these agreements were in place for all medical staff and the provider had implemented a practising privileges policy June 2016. However, there were inconsistencies in their appropriate content.
- We reviewed the six practising privileges folders. Each held a checklist of what should be included: two references, DBS check, General Medical Council (GMC) registration, indemnity insurance, appraisal date, qualifications and identification. We found all folders contained GMC registration, indemnity, qualifications and identification. Only two out of the six had evidence of up to date appraisal.
- We found two out of the six folders contained three references written by the chief executive at Raphael Medical Centre. Two of the references were in one of the practising privileges folders. We asked the director responsible for human resources who informed us "something is better than nothing". Best practice advised by the government organisation NHS Employers, states 'references are to be sought from last known employer and sourcing a character or personal reference, preferably from a business acquaintance who are not related to the applicant and who do not hold any financial arrangements with that individual'. Section 2.6 of the hospital's practising privileges policy states: 'the responsible officer has a statutory responsibility to ensure appropriate employment checks by obtaining appropriate references'.
- Additionally, two folders contained DBS certificates last updated in 2010. Government guidelines state there is no official expiry date for a DBS; it is up to the employer to decide if and when a new check is required. However, best practice advised by the government organisation NHS Employers, states 'employers must ensure they have robust recruitment procedures and systems in place so they are assured their staff are, and continue to be, fit to practice'. Section 4.1 of the hospital's practising privileges policy states: 'medical practitioners will need to apply for a DBS at enhanced level, countersigned by a representative of the Raphael Medical Centre. DBS checks are required to be updated according to risk/ change of circumstances and in line with DBS and the centres own requirements. All medical practitioners will have to apply to the DBS for a new disclosure certificate at enhanced level every three years and as a pre-condition for retaining practising privileges'. This meant the hospital was not following its own policy.

Staff, teams and services working together

Multidisciplinary working

- We asked the hospital to describe how they ensured the involvement of local authority social services staff where necessary. They explained that all patients were referred by, and then subsequently funded by, their relevant Clinical Commissioning Group (CCG). The hospital invited all commissioners to the case conferences. The first one occurred eight to 10 days following admission, then at six weeks and three monthly after. If commissioners failed to attend then the hospital sent a detailed report to them to keep them fully informed. The hospital commenced discharge planning on admission.This process was closely coordinated with the relevant local authority social services team.
- The hospital told us that they received 63 referrals for admission between October 2015 and September 2016. All of these patients had complex disabilities and the hospital assessed all the patients within two weeks of the referral.
- We saw an improvement in multidisciplinary working since our last inspection. Therapists and nursing staff were now working cohesively together. For example, staff told us therapists trained nursing staff on the correct application of splints for each individual patient and how to carry out risk assessments.
- Therapists could hand over any changes or outcomes of treatment for a patient verbally to the assigned key worker. We saw evidence whereby therapists had

provided pictures of the correct positioning of patients in chairs or the correct application of splints in patient records. This ensured continuity of care for each patient.

- We saw the level 1 ward in the main building kept a staff communication book. We reviewed the book and found messages including information from the physiotherapist, staffing issues, patient updates, messages for keyworkers and updates to multidisciplinary policies. We observed nursing staff shared this information at handover.
- The multidisciplinary team held case review meetings every six weeks. At the initial meeting, staff discussed goal setting and the benefits of different treatment with the patient and their family. We saw records of the multidisciplinary meetings in the patient's notes, which outlined key discussion items and action points. Staff told us relatives received a copy of the meeting notes.
- Staff told us specialist tracheostomy trained nurses visited patients with a tracheostomy on a regular basis. We saw they documented their input in the patient notes.
- Every Wednesday between 2.30pm and 3.30pm all staff attended a multidisciplinary meeting. This was also an opportunity for training sessions and for staff to disseminate learning from courses attended.
- Nursing staff told us the integration with other disciplines such as physiotherapy was good and they could easily access other therapies.
- Staff told us the community tissue viability nurse provided support by delivering training and advice regarding pressure area care and wound care.
- At the focus group all staff spoke positively about their experience working at the hospital. They told us everybody worked as a team and supported each other. They were not asked to work outside their scope of practice.

Seven day services

- The consultants provided a 24 hour on call service as and when required. The day to day medical service was provided by the in house physicians who dealt with any routine and emergency situation in consultation with the relevant consultant assigned to the patient.
- Each day after 8pm medical cover was provided by telephone advice. Staff told us they were confident to contact the doctor out of hours and they did not feel it was necessary for a doctor to be on site 24 hours a day. Additionally they would contact emergency services for a deteriorating patient if required.
- Patients had access to therapy service seven days a week 8am to 8pm. This meant the weekend did not affect patient rehabilitation.

Information

- Staff with practising privileges generated patient medical records, which other staff could access.
- The hospital kept an integrated care record for each patient, which meant different groups of healthcare professionals could access information in a timely way.
- The hospital sent patient care plans to the GP on discharge.
- If a patient transferred to another hospital for admission, the hospital recorded this on the hospital admission record and kept the discharge letters within the patient notes. This allowed for continuity of care.
- The level 1 ward in the main building had an extensive number of files containing policies, checklists and information for staff. We counted 46 files on two shelves in the nurse's office. There was no process in place to review these folders to ensure the information contained was relevant and up to date. However, staff told us they accessed hospital policies on the hospital's intranet.
- The notice board in the reception displayed the 'one minute read' for staff explaining news, events and reminders. We saw the February 2017 issue explained the employee of the month, CQC inspection, staff parking and duty of candour. Additionally we saw the information board contained the booklet produced by the Department of Health regarding Independent Mental Capacity Advisor (IMCA) service.

Requires improvement

Long term conditions

- The special care unit provided pictorial information leaflets for staff whose first language was not English. The leaflet included pictures of equipment (for example nebulisers) and staff received this in their welcome pack. We saw managers had designed a separate sheet of paper in patient's notes to assist with correct terminology. Staff told us the hospital provided beginner and intermediate English language training for relevant staff. Staff attended classes during work hours.
- A notice board on the level 2 ward in the main building displayed information for staff. This included single use medical devices, protocol for use of diazepam, emergency contact numbers, dislodged or displaced tracheostomy tubes flow chart and a needle stick injury poster.

Consent

Consent, MHA and DoLS

- The hospital had a policy for consent to examination or treatment. The policy demonstrated the process for obtaining consent, documentation and responsibilities for the consent process. We heard staff explaining to patients the planned treatment involved and asking patients if they wanted to continue with treatment. This was in line with the hospital's consent policy.
- At the time of inspection no patients were subject of an order made by or have a deputy appointed by the Court of Protection with powers to take decisions about the service provided. Additionally no patients had given another person valid and active lasting powers of attorney with authority to take decisions about the service provided.
- Information provided prior to inspection informed us eight patients had a mental health disorder and were in receipt of a formal care plan under the Care Programme Approach. Data showed 40 patients, who had their liberty, rights and choices affected, were supported by care plans. Additionally 18 were subject to an authorisation under the Deprivation of Liberty Safeguards (DoLS). The provider had informed the CQC of all DoLS statutory notifications as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The hospital trained all clinical staff to complete DoLS assessments and paperwork. A hospital administrator sent the required paperwork to the correct local authorities. We saw a spreadsheet, which listed all patients with a DoLS in place and their review and expiry dates.
- We saw staff appropriately applied for authorisation of DoLs for patients. Staff completed further requests for standard authorisation to ensure the DoLs authorisation was in date for the duration of the patient's admission. We saw evidence of completed DoLS paperwork in patient notes, recognising staff worked in the patients' best interest.
- The hospital had a policy which contained guidelines adhering to national guidance with regard to restriction and restraint in order to ensure restraint was only used when appropriate. We observed there were risk assessments available for the three types of restraints available for use (lap, foot and head straps).
- The hospital had clear procedures for patients subject to the Mental Health Act (MHA). We reviewed arrangements for the detention of patients under the MHA and they were appropriate, compliant with legislation and known by staff.
- We saw assessments of capacity were carried out using a standardised template which ensured the requirements of the MCA Code of Practice issued by the Department of Health were met.
- All patients had a record of their mental capacity assessment. We saw staff assessed a patient's mental capacity every six months throughout their admission. We also saw consent forms for less complex decisions such as blood taking, therapy and bed rails were completed. We saw evidence that family members had been involved in these discussions and staff told us they used the next of kin as the equivalent of an IMCA.
- Level 1 ward in the main building kept a 'My Advanced Care Plan' folder in the nurse's office. This contained a checklist for each patient and included if an advance care plan form had been given to the patient, received back from the patient, if a meeting with patient/ relatives/advocates had been held and whether a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) order was in place. However, the checklist was unclear and staff did not complete this for each

patient. Staff crossed through discharged patients and added new patients to the list, which made the checklist unclear. There was also a hand drawn legal status table for each patient. All entries in the folder were handwritten and illegible in most cases.

- At the time of inspection no patients had made an advance decision to refuse treatment that may affect how the service cared for or supported them.
- During our visit, we checked medical records and we viewed two DNACPR forms that complied with national guidelines. We saw all decisions were recorded on a standard form, signed by an appropriately senior clinician and evidenced that there had been discussion with the patient or relative. The form was kept in the front of the patients notes.
- The Resuscitation Council (UK) guidelines state every organisation must have at least one resuscitation officer who would be responsible for audit of DNACPR which is mandatory.

- We saw the hospital audited DNACPR forms in August 2016 to determine where the order was completed and if there was an appropriate assessment recorded. The results showed no patients had a DNACPR form in place at the time of the audit.

Are long term conditions caring?

Good

We rated caring as good.

Dignity, respect and compassion

Compassionate care

- Overall the staff, in all areas of the hospital, were caring, well-meaning and showed they genuinely cared for the patients. We saw staff interacting with patients in an attentive manner. They were patient, kind and took time to explain what their treatment was going to involve.
- During our inspection we observed staff providing care that was sensitive and compassionate. Staff maintained patients' privacy and dignity. For example, we saw care interventions were carried out behind closed doors. We observed staff placed signs on doors 'do not disturb, personal hygiene in progress'. We observed staff were kind and patient in their approach and we saw examples of difficult situations being sensitively managed.
- Patients told us, and we observed, call-bells were left within reach of patients and were answered promptly. In addition we saw staff respond promptly to requests for assistance.
- We spoke with nine patients and three of their family and friends who were positive about the care received. Comments included "staff invest time in getting to know relatives".

Understanding and involvement of patients and those close to them

- The patients and their friends and family we spoke with told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- Patients and those close to them were involved in the decision making process from pre admission through to discharge. We saw all necessary information about care and treatment was provided in appropriate formats and patients were supported to fully understand their implications. Using a goal setting approach was paramount to their involvement and working in partnership supported each patient's individual decision making process of their treatment and care.
- Each patient had their own individualised care plan and both the patient, where possible, and their friends and family were involved in the process. Patients and their representatives were invited to attend the consultant's weekly ward round and all case reviews. Friends and family we spoke with confirmed they were invited to case reviews.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with feeding, personal care and attending therapy sessions with patients.

Emotional support

Requires improvement

Long term conditions

- Staff were aware of the challenges of managing expectations of families and managing treatment for patients with long term conditions. Staff in the focus group told us sometimes patients, due to their diagnosis, could be unique and challenging and the staff had a sense of pride in providing good care.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance. Staff could access spiritual support, counselling services and other psychological support for a patient if it was needed.
- Each patient was assigned two key workers who worked opposing shifts to provide continuity of care for patients. Patients told us they liked having regular carers.
- It was acknowledged caring for the patients at the hospital was physically and emotionally demanding. A formal support network was not provided for staff. However, we found staff provided support and emotional support for each other.

Are long term conditions responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as good.

Services planned to meet needs of people

- Close links had been developed between the provider and the relevant commissioning services. We were told there were frequent meetings to consider how the provider can respond to the needs of the local population. The hospital produced a pre admission report for the clinical commissioning group. This was reviewed and funding agreed prior to the patient moving into the service.
- Preadmission assessment and goals for referred patients were agreed with the commissioners prior to, upon and following admission. Regular review meetings were held to which commissioners were invited. Reports were submitted with recommendation for the services provided. All information was provided to out of area commissioners and the provider actively worked in partnership to facilitate timely interventions if required. We saw examples of review meetings and reports to commissioners.
- The provider was actively involved in developing the Kent and Medway wide strategy for neuro-rehabilitation. This work closely reflected on the subsequent development of their services and the need to develop more acute level 1 and 2 rehabilitation services. Through regular family meetings and annual surveys the provider was able to notify the commissioners of services and governing bodies of any changes in the perceived need of current or future patients.
- The local NHS rehabilitation unit closed in March 2016 and Raphael Medical Centre was able to support patient transfers who would have been re-referred within West Kent.
- The hospital had one of the only two hydrotherapy pools dedicated for neurorehabilitation in the Kent and Medway area.
- Records showed us patients received a prompt diagnosis of any changes in their condition with an appropriate referral for service provision and treatment. The hospital had a private contract for the arrangement for collection and testing of blood tests and microbiology.

Meeting needs of different people

- Ethnicity and diversity training was not part of the mandatory training. However the provider told us they were in the process of including this in the matrix.
- Dementia training was provided for all staff with an update every two years. Data showed us all staff had completed the training.
- The hospital had access to translation services for face to face and telephone interpreting. This could be booked through a centralised booking system.
- We saw patients who were unable to communicate used non-verbal communication charts successfully.

We saw evidence of electronic assistive technology systems appropriate for these patients being used. Patients' individual communication needs were documented in their care plans.

- We saw all areas were suitable for wheelchair users or those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients. Before admission a patient was assessed for their individual needs and specific equipment was ordered and available upon admission, for example hoists and slings. The hospital provided therapy exercise equipment specific for wheelchair users.
- We saw patients' rooms were bright and airy and made to look like a home environment rather than a clinical area and some reflected the resident's individuality. Windows looked onto gardens.
- The special care unit had a private garden area accessible to escorted patients. Additionally the building had a seating area in the main lounge and a separate lounge which provided more privacy. Both areas provided visibility for staff to see if other members of staff and patients required assistance. This meant they were able to keep patients safe.
- The grounds of the hospital were accessible to patients and their family and friends. Family and friends who wanted a private space were able to use the sitting rooms in the main building and Tobias House.
- The hospital did not have a designated area or the facilities for friends and family of patients to stay at the hospital. We were told if a flat was available in the step down facilities this could be offered for a limited time and in an emergency. However, we saw staff were able to provide information on local places to stay and had also an arrangement with local residents who would rent out rooms to relatives.
- The provider encouraged and supported social integration from the point of admission and throughout a patients stay. Staff risk assessed every patient that wanted home leave and kept a record of this in the patient's notes. This highlighted any concerns or any barriers to the patient going home which enabled the staff to put measures in place to overcome these. For example, we saw staff were arranging for a patient to go out to meet friends for dinner in a local restaurant.
- The manager of the special care unit showed us the card they had produced with ward details for information regarding any concerns the public wanted to raise when patients are out on escorted visits.
- We saw therapists tailored treatment plans to meet individual patient needs. For example, some patients would have a treatment to improve the circulation and decrease tension in muscles prior to exercise therapy. Other patients had a relaxing therapy at the end of the day to improve the quality of their sleep.
- There was a variety of equipment available in the gym for patients to exercise with. Staff told us they had no issues with accessing new equipment, when required.
- We saw level 1 ward in the main building kept a 'patient monthly showering monitoring record'. Staff told us they recorded when the patient had a shower and this should happen at least every other day.
- Each patient had a board in their bedrooms displaying their schedule for the week. The schedule was updated weekly and was based on each patient's needs and objectives.
- We saw an advance care plan was in place which set out individual future preferences for 39 patients.
- The provider told us they recognised some patients, as a result of their complex needs, may need long term care and they had a number of specific beds for this population. Additionally some patients may need palliative and end of life care. This did not mean rehabilitation processes were terminated and staff were as actively involved in their care as those patients on an active rehabilitation pathway.
- We saw the hospital's policy for the care of the dying. The policy was based on a philosophy of care and listed the ten 'dying person's bill of rights' (for example, the right to be treated as a living human being until death). However, the policy did not consider the current recommended standards by British Society of Rehabilitation Medicine (BSRM) for advance care planning and end of life care or Royal College of Physicians guidelines. The hospital's

allocated lead for end of life care had resigned from the hospital before our inspection. The hospital was in the process of recruiting a new lead. Staff told us support was provided by the local hospice and palliative care team when required.

- The provider could access spiritual support for a patient's individual religious denomination. This would be determined at the pre admission stage when the provider assessed people's personal, cultural, social and religious needs.
- Observations we made in the dining room showed staff provided patients with support for feeding if required. We found patients and those supporting them had access to hot and cold drinks at all times.
- Staff were provided with free food and drinks. Staff we spoke with told us although the choice was limited the food was nice.
- We saw visiting times were displayed on the notice board in the reception. These were available between 10am and 8pm, all visitors were to sign in at reception and display a visitor's badge. Visitors were able to purchase tea (£2), lunch (£4) and supper (£4).

Timely care and treatment

Access and flow

- At the time of inspection, 31 patients were in the main house, eight patients in the special care unit and nine patients in Tobias House.
- The hospital received 63 referrals for admission between October 2015 and September 2016. All patients were assessed within two weeks of referral and had complex disabilities. Prior to inspection the provider informed us they had 12 people on their waiting list for admission. The provider prioritised referrals for admission on the need of the patient and their current location.
- There were arrangements to ensure patients admitted to the hospital were suitable and would benefit from the service offered. We saw the admission, transfer and discharge guideline which took into consideration the British Society of Rehabilitation Medicine (BSRM) guidance for best practice for specialist nursing home care for people with complex neurological disabilities.
- When a new referral was received the admissions committee met to discuss the suitability of the patient based on the information received. If the referral was suitable a pre assessment of the patient was arranged with members of the multidisciplinary team, appropriate to the patient's individual needs. If the referral was appropriate, the provider worked in partnership with the commissioning group and the admission process was started.
- Two weeks before admission a specialist team assessed the patient to ensure appropriate equipment was ordered and individual needs met. New admissions were scheduled to arrive before 6pm on the day of arrival. Records showed us a medical diagnosis was completed within 24 hours of admission including suitable tests, for example bloods and MRSA screening. A nursing assessment was completed within 72 hours and a therapy assessment within seven days. The patient was reviewed after six weeks and family and CCG were invited to attend.
- We saw the process of discharge planning was started upon a patient's admission. Every patient was reviewed every four weeks and their discharge status assessed. We saw comprehensive discharge records, which included detailed information from each staff group, medical, nursing and therapy staff.
- The provider told us due to their focused discharge planning a bed could be made available in a timely manner. Effort was made to have an emergency bed available at any given time. However, this was not always possible given the demand for beds.

Complaints

- We saw a copy of the hospital's complaint process was displayed on the notice board in the reception. Patients and their friends and family were supplied with a copy of the procedure upon admission. We spoke with patients and their relatives who confirmed they had received this information and knew who to contact if they had concerns.
- The hospital's formal complaints process was aligned to the Independent sector Complaints Adjudication Services (ISCAS) which is endorsed by the Department of Health and conforms to NHS procedures. An initial acknowledgement was required within two working days of a written complaint and a full response within

20 working days. If a complaint was escalated to a further stage the complainant would be given the information of who to take the complaint to if they remained unhappy with the outcome. The individual responsible for overseeing the management of complaints was the chief executive.

- Prior to inspection the provider told us between October 2015 and September 2016, they had received seven compliments and three complaints. These complaints were handled under the formal complaints procedure. We were told these were responded to in a timely manner, the complainant was supported and an apology was given.
- During the inspection we reviewed the files of five complaints. For all five complaints we saw there was no evidence of an investigation, discussion with staff involved or changes made owing to the outcome. Additionally, lessons learned were a broad statement and there was no evidence this was shared with staff. We saw two of the complaints received an acknowledgement within the two day response framework and none for the responses explained the formal process and how to contact ISCAS.

Are long term conditions well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership and culture

Leadership

- The structure of the management of the hospital consisted of a chief executive who was answerable to the board of directors. There were departmental directors for therapists, nursing, human resources and finance, medical and hotel services. Each ward area had a manager.
- The senior management team met every week. We saw the minutes of these meetings which showed all aspects of the hospital were discussed. Previous outstanding actions were updated and current issues were actioned with delegated responsible persons.
- Team leaders met monthly. We saw the minutes for the meetings in August, September, October and November 2016. Set items on the agenda included legislation/regulations/policies, staffing, patients, relatives and clinical issues. Action plans were decided with allocated responsible persons. We saw the following month's meeting updated the team on the actions. For example the October minutes reported the sluice machine in Tobias House was not working and costing for the replacement parts had been sent to the chief executive. The November minutes showed the machine had been mended and was in working order.
- We asked the provider to demonstrate how they were working to collect data according to the Workforce Race Equality Standards (WRES). Any independent unit that undertakes work for the NHS that generates an income of over £200,000 in any twelve month period is obliged to collect and publish data. This includes, but is not limited to, the ethnicity of its staff and the positions held by those staff. The provider replied they did not believe they were required to collect the data as they considered it voluntary and they already employed a diverse workforce. The requirements of WRES are defined under the full length NHS Standard Contract 2017/18. Service condition 13.6 clarifies the provider must implement the standard and submit an annual report. In addition, the reporting requirement in item 12 schedule 6A of the particulars under National Requirements states: 'the requirement to submit a report is not at the discretion of the commissioner – only the format, timing and delivery of the report are for local agreement'. The provider of Raphael Medical Centre was unaware of their obligations with regards to WRES and had not given consideration as to how they might meet this requirement. Following the inspection the provider informed us they collected ethnicity information as part of the human resources system. the provider was in communication with the national WRES implementation team to clarify reporting requirements and arrangements.
- Culture
- Sickness rates provided for the previous three months before inspection was less than one per cent for all staff employed. In the 12 months before inspection,

28% of total staff left employment at the hospital and 29% were recruited. Most of these were predominantly rehabilitation assistants. This demonstrated the hospital had a high turnover of staff. The provider explained this was because some overseas staff left once they have obtained their registration. In addition the nature of the work and its unique environment was not suitable for all.

- At our last inspection we found the chief executive maintained control of every aspect of the hospital. At this inspection we found duties had been delegated to directors and managers of departments. Staff told us they welcomed these responsibilities and felt empowered to make decisions for the good of the hospital and its patients.
- The provider told us they prided themselves on their 'open door' policy whereby patients and their relatives were able to discuss their care and treatment. This could be achieved at any time, should they be happy or not pleased with their care and treatment.
- Staff we spoke with told us they felt supported by team leaders. Staff were encouraged to escalate complaints and concerns. Medical staff told us there was a zero tolerance of bullying at the hospital and all staff felt supported by the chief executive.
- Staff told us since our last inspection, 'things were better' and the culture of the hospital had changed. The last inspection provided an opportunity for learning for all to improve the service. Staff felt listened to when requesting resources and on the whole, requests were granted. We were told staff felt empowered to make clinical decisions, for example the application of splints. They received positive feedback from managers.
- **Vision and strategy**
- The provider told us that their vision was to develop and provide a rehabilitation hospital, based on the anthroposophical image of humans, which recognised people as being of body, soul and spirit. They believed they could bring about an improvement in the health of individuals with a combination of medical treatment and complementary therapies. Additionally, the provider believed each patient should be given the opportunity to improve irrespective of their original diagnosis. Staff we spoke with were supportive of this approach and positive regarding its outcome.
- Additionally, the provider aspired for Raphael Medical Centre to be the hospital of choice to enable patients to be supported in the recovery process and maximise their independence. They would like patients to be transferred out to community placements earlier which would facilitate the hospital to accommodate more acute patients.

Governance

- The hospital had an audit plan which included auditing medicines, documentation, infection control, nursing care plans, preventative maintenance and health and safety. We saw records which indicated these were happening four times a year in line with the plan. However, we saw no evidence of an effective auditing system for monitoring cleaning standards as stated in the hospital's operational policy.
- The hospital did not have suitable governance arrangements in place for the monitoring of the six doctors working under practising privileges agreements. We found some doctors working under these agreements did not have appropriate records and assurances in place. Four folders did not contain up to date appraisals, two did not contain appropriate references and two did not contain the disclosure and barring service (DBS) checks required.
- We were told the ethos of the provider, regarding complaints and concerns, was an 'open door' policy which enabled patients and their friends and family to discuss their problems and complaints with any member of staff including senior managers. We were told it was rare for a complaint to reach the formal process as all concerns were handled amicably. However, there was not a system for recording these informal concerns and complaints to enable the provider to monitor trends, outcomes and dissemination of lessons learned.
- At our last inspection we found the governance arrangements did not effectively monitor performance and risks or provide appropriate assurance to the board. At this inspection we found the provider had implemented a new governance framework. The

medical advisory committee (MAC), safeguarding committee and health and safety committee all reported to the clinical governance committee (CCG). The committee met four times a year and we saw the minutes of meetings for February, June and September 2016. We found issues raised at CCG meetings were sufficiently followed through. There was individual responsibility for actions assigned and there were updates on the progress or efficacy of actions decided. The minutes contained action logs.

- The CCG was made up of representatives from each staff group at the hospital and chaired by the chief executive. The committee consisted of external representations (a nurse and a health care solicitor) to enable the provider to be given a different perspective. We were told there were plans for an additional representative, a GP with a background in anthroposophical medicine. The CCG had terms of reference and reported to the board. The named responsible officer attended the CCG and was chair of the MAC.
- The MAC met every three months and we saw the minutes of the last four meetings. The minutes showed the key governance areas such as practising privileges, complaints, incidents, health and safety and feedback from the clinical governance committee were discussed each time.
- Since our last inspection the provider had formed a clinical risk register and this was started in September 2016. We saw there were five risks listed and these all contained a description, a responsible person, impact and probability, progress and completed actions. The risks were: exposure to clinical waste, patient fall, preadmission assessment, administration of medicines and cross infection.
- **Engagement and Involvement**
- We asked the provider for results of staff surveys. We were told 'the last annual survey was completed in September 2015 and was reported in the previous inspection'. Following a review the provider felt the survey was not suitable for staff to understand and did not provide enough quality data in order for improvements to be made and best practice highlighted. The provider told us this was in the process of being redesigned in a similar format to the PLRCE (patient led review of the care environment). The provider used other methods to collect the views of staff.
- We saw the results of the staff health questionnaire, 2016 was provided in the form of a bar chart. This consisted of seven sections which included workplace environment, equipment, physical environment (for example moving and handling), substances, processes (for example working at heights) and work organisation (for example work hours). Overall the response was marked as 'no problem'. The final question asked when staff would recommend a management review and overall this was answered as annual.
- The results of the staff work related stress analysis report 2016 was provided in the form of a bar chart. This showed staff responses to 39 given statements. The results were divided by professionalisms (therapists, nursing) and not individual areas of the hospital. Statement five related to 'I am subject to personal harassment in the form of unkind words or behaviour' and statement 21 'I am subject to bullying at work'. The responses to both statements were predominantly 'never'; however the other responses (seldom, sometimes, often and always) also had replies.
- The hospital acknowledged staff with an 'employee of the month' award. We saw the employee awarded for January 2017 was displayed on the noticeboard in reception and said "a grateful thanks in recognition of your helpful nature, exemplary attitude and compassion". We spoke with the member of staff who had received the award who was proud of the achievement and other staff told us it was an additional benefit.
- The hospital had a family meeting held every other month. These consisted of peer support, feedback on services and an educational training programme. Staff told us this proved to be a vital part of the service to all users. Families were actively involved in choosing the topics for the meetings and this also involved choosing trips out.
- The hospital held monthly patient meetings with specific training sessions. We saw the schedule for

2017 displayed. Sessions were for each month and included 'disorder of consciousness and the year ahead', 'demystifying tracheostomy', 'superbugs need superheroes: working together to protect your loved ones', 'self care including mindfulness and relaxation', 'what is neurorehabilitation?'and the 'Christmas special'.

- We saw the results of the patient satisfaction questionnaire, August 2016 provided in the form of a bar chart. This consisted of 40 questions which included: 'If you have anxieties or fears about your condition or treatment, does a doctor discuss them with you?', 'Do you get enough help from staff to eat your meals?' and 'How clean is your room, the toilets and bathroom?' Overall the responses were positive and 91% rated their quality of treatment as excellent or good.

- **Continuous improvement**

- Staff confirmed they had an active research portfolio which enabled them to audit outcomes of therapies, medications and processes. We saw they had presented their findings at world conferences and had research articles published in clinical journals. We were shown details of current research projects which were in progress and relevant to their field of expertise. For example Wessex Head Injury Matrix (WHIM) for auditing outcome in Prolonged Disorders of Consciousness (PDOC).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must perform cleaning audits as per the hospital's schedule and the hospital must be able to show the results of these are consistently acted upon and used to improve service.
- The provider must ensure they have assurances doctors working under rules of practising privileges have appropriate references and criminal checks as per best practice guidelines.
- The provider must ensure that action is taken when fridge temperatures are recorded outside of the safe range.

Action the provider SHOULD take to improve

- The provider should consider systems to ensure the safety and quality of the water supply throughout the premises and in the hydrotherapy pool.
- The provider should ensure that it provides feedback to staff regarding complaints received and consider systems to ensure there is appropriate learning from the outcome.
- The provider should have plans in place to implement the Workforce Race Equality Standard (WRES) requirement.
- The provider should collate the views of staff to develop services with a current staff survey.
- The provider should provide feedback to staff regarding safety incidents and consider systems to ensure there is appropriate learning from such incidents.
- The provider should consider how it ensures waste is stored to meet current guidance.
- The provider should develop business continuity plans that mitigate identified risks.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Where medicine fridge temperatures in the main building had been recorded as outside of the recommended safe range, appropriate actions had not been taken. This breached Regulation 12 HSCA (RA) Regulations 2014 Safe Care and treatment parts 12 (2) (g).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Persons providing care or treatment to service users did not all have practising privilege evidence of appraisals, references or disclosure and barring service (DBS) checks to ensure they were safe to undertake their role. This breached Regulation 17 HSCA (RA) Good Governance parts (2) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Cleaning audits were not performed as per the hospital's schedule and the provider was unable to show the results of these were consistently acted upon and used to improve service.

This section is primarily information for the provider

Requirement notices

This breached Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Parts 15 (1) (a).