Ascot Rehabilitation Ltd.

Quality Report

Ascot Rehabilitation Ltd
Unit 1
SW19 2PT
Tel: 020 3212 0839
Website: www.ascotrehab.com

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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	**Outstanding** ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Good** ●

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection of Ascot Rehabilitation Ltd with an announced inspection on 23 and 24 May 2018.

Ascot Rehabilitation Ltd offers inpatient, outpatient and outreach rehabilitation predominately for people who have a neurological condition or spinal injury, amputation or musculoskeletal problems as an independent provider. Their main operations are the provision of neurological rehabilitation to private overseas patients and individual self-funding or case management patients.

During our inspection we visited the following registered locations:

Ascot Rehabilitation at Bagshot Park

We inspected the provider because this was part of our comprehensive Wave 2 pilot community health services inspection programme .

We rated Ascot Rehabilitation Ltd as outstanding overall.

The service was rated outstanding for effective, caring and responsive. We rated safe and well-led as good.

Our key findings were as follows:

- There were clear defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse
- The service monitored and reviewed their practices and safety systems regularly ensuring compliance was up to date with the most recent regulations and legislation.
- Staffing levels were appropriate and tailored to patients needs.
- Areas we visited were visibly clean, staff demonstrated good infection control practices and procedures.
- During this inspection we found that the care being delivered was meeting the needs of the patients. Staff consistently put patients at the centre of everything they did.
- Staff throughout the organisation worked to ensure individual needs were met. Patients and carers with additional needs were supported.
- Managers and staff embraced an improvement culture and tried hard to improve the quality and sustainability of services.

We saw several areas of outstanding practice including:

- Use of doppler scanning to assess patients risk of developing pressure ulcers in addition to standardised assessments when the initial signs of skin fragility are shown.
- Use of the core values assessment to promote dignity to patients.
- Innovative treatments such as the robot assisted automated treadmill and a self initiating arm and hand therapy rehabilitation exercise device.
- The service used a transdisciplinary model of care that promoted a truly whole person approach to rehabilitation. We saw continuity of care and a staff working on patient centred goals while helping manage expectations and needs.
- The service had an imbedded culture of care for the patient and supporting families and social networks to work as a whole.
- There was an add-on hospitality service which supported patients and their families to address any requests such as overnight stay, taxis and transport as well as accessing social events.

However, there were also areas where practice could be improved.

Importantly, the provider should:

Summary of findings

- Ensure all relevant mandatory training is reviewed and updated as per service policy.
- Consider ways to improve access to all equipment and promote safe practice in the storage room.
- Address the safety and contamination risk of the clinical waste compound with the landlord. Bins and storage areas should be locked and the storage area accessible only to members of staff who require access to it as stated in the Health Technical Memorandum 07-01: Safe management of healthcare waste.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

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Our inspection team

The team that inspected the service was comprised of a CQC inspection manager, two CQC inspectors, and one specialist advisor with expertise in occupational therapy.

The inspection was overseen by Catherine Campbell head of hospital inspection for the south east region.

Why we carried out this inspection

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected this provider as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We carried out an announced visit on 23 and 24 May 2018. During the visit we were shown a service presentation with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the service.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Information about Ascot Rehabilitation Ltd.

Ascot Rehabilitation Ltd offers inpatient, outpatient and outreach rehabilitation predominately for people who have a neurological condition or spinal injury, amputation or musculoskeletal problems as an independent provider. It treated private patients from all over the world, working closely with consultants, embassies, health insurance providers and legal firms. It did not provide treatment for NHS patients.

Ascot Rehabilitation Ltd is registered to provide the following regulated activities: Diagnostic and screening procedures and Treatment of disease, disorder or injury.

Ascot Rehabilitation Ltd has a registered location which is Ascot Rehabilitation at Bagshot Park.

Ascot Rehabilitation at Bagshot Park offers services of doctors consultation, doctors treatment and rehabilitation. The location supports the following service user bands: Dementia, Older people, Physical disability, Sensory impairment and Younger adults.

Ascot Rehabilitation Ltd has been inspected once since registration. The inspection occurred on 3 September 2013 and met all CQC national standards.

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?

Good

Our overall rating of safe was good. We rated it as good because:

- We found there were systems, processes and practices that kept people safe and safeguarded from abuse. Staff knew how to support vulnerable patients and raise safeguarding concerns.
- We saw the service was clean and infection risk was prevented and well controlled.
- Staffing levels and skill mix were appropriate and planned and adjusted to patients' needs.
- The service assessed, monitored and managed risks to people continuously. These processes were regularly reviewed to keep in line with best practice.
- We found patients notes were accurate, organised and up-to-date containing all relevant information to provide safe care.
- Staff met good practice standards as described in relevant national guidance.
- Openness and transparency about safety was encouraged. Lessons were learned and communicated to support improvement in patient care.

However:

- We found that the mandatory training target was not consistently being met. We did however receive assurance that this was being addressed and the service was continuing to improve its compliance.
- We saw there was a safety and contamination risk regarding the clinical waste compound. Bins were unlocked and the area was accessible to everyone.

Are services effective?

Outstanding

Our overall rating of effective was outstanding. We rated it as outstanding because:

- We saw a truly holistic approach to assessing, planning and delivering care and treatment to all people involved with the service.
- The service was proactive in providing innovative and pioneering approaches to care and continuously sought best evidence based practice to support the delivery of high quality care.

Summary of this inspection

- All staff we spoke to were actively engaged in monitoring and improving quality and outcomes for people using the service as well as supporting them during discharge. This was recognised by accreditation through credible external bodies.
- Staff told us they were proactively encouraged and supported to acquire new skills and share best practice. The service recognised staff's skills, knowledge and competence was key to ensuring high quality care.
- The service identified itself as one and staff worked collaboratively to deliver joined up care to all people who interacted with the service. This included the provision of care as well as the promotion of healthier life-styles.
- We found that practices around consent and information delivery were actively monitored and reviewed to improve how people were involved in making decisions about their own care.

Are services caring?

Outstanding ☆

Our overall rating of caring was outstanding. We rated it as outstanding because:

- All patient and family members felt truly valued and respected as individuals by the service. We heard numerous examples of how the service empowered and built partnerships between themselves, patients and their partners in their care and emotional needs.
- We saw an embedded practice of person centred care with highly motivated staff that inspired care and dignity. Relationships between service users and staff were close, respectful and supportive.
- Staff recognised and respected the totality of people's needs. Patients told us their personal, cultural, social and religious needs were always taken into account and staff did everything to meet these.
- We found that people were always treated with dignity by all those involved in their care. Patients told us of how they were always enabled to gain as much independence as possible and this made them proud of their achievements.
- Patients consistently told us they felt "nothing was ever too much to ask for".

Are services responsive?

Outstanding ☆

Our overall rating of responsive was outstanding. We rated it as outstanding because:

- The service was tailored to meet the needs of individual people and was delivered in a way that ensured flexibility, choice and continuity of care.

Summary of this inspection

- We found that services were flexible, provided informed choice and ensured continuity of care. The service provided add-on services such as hospitality and taxi services which ensured that patients and families requests could be tended to.
- Facilities and premises met the needs of all people using the services.
- There was a proactive approach to understanding the needs and preferences of different groups of people. We heard of examples were staff adapted to the needs and requests of people to access appointments in a way and time that suited them.
- The service demonstrated they were responsive, actively managed and learned from complaints.

Are services well-led?

Good

Our overall rating of well-led was good. We rated it as good because:

- The leadership, governance and culture promoted delivery of high quality person centred care.
- Leaders were knowledgeable about issues and priorities for the quality and sustainability of services and had plans to address them.
- We found that leaders at every level were visible and approachable. Staff knew who their leaders were and felt they could have open and honest conversations with them.
- There was a clear statement of vision and values.
- We found there were quantifiable and measurable outcomes to support strategic objectives. These were inclusive and supportive of the patient centred culture existent within the service.
- There were opportunities for staff at all levels to have the development they needed. However, staff reported the response to training had been slower over the past year.
- Leaders described a holistic understanding of performance which integrated the views of people who used the service with quality, operational and financial information.
- The service is open, transparent and collaborative with all stakeholders. This was evident through engagement and the publication of the service's yearly quality report online.
- There were organisational systems to support improvement and innovation work. The service made effective use of internal and external reviews and used feedback as a learning opportunity to improve the service.

However:

Summary of this inspection

- Leaders recognised that the service's vision statement may need to be reviewed as the service has evolved since its inception.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good	Outstanding	Outstanding	Outstanding	Good	Outstanding
Overall	Good	Outstanding	Outstanding	Outstanding	Good	Outstanding

Outstanding

Community health inpatient services

Safe	Good
Effective	Outstanding
Caring	Outstanding
Responsive	Outstanding
Well-led	Good

Are community health inpatient services safe?

Good

Mandatory Training

The service offered members of staff a welcome booklet identifying key mandatory training subjects depending on their professional capacity. These were signed as they were completed. We saw evidence in the booklet that staff were responsible for keeping mandatory training up to date and were regularly audited for compliance as per service policy.

Human resources and clinical line managers reviewed training records and were responsible for identifying gaps and training needs. Additionally, supervisors and heads of therapy oversaw staff training matrix's and identified training gaps. This was aimed at ensuring that mandatory training would be kept up to date.

The service identified a target of 90% mandatory training rate completion for members of staff.

Compliance for mandatory training for medical staff (Consultants and Registered medical officer) during the time of inspection was as follows: equality and diversity 67%; information governance 83%; moving and handling 83%; fire safety 83%; infection control 100% and resuscitation 50%.

During our inspection the service did not meet the training target in five out of the six modules for medical staff. However, we saw evidence and were assured that consultants were being notified of their training gaps. We were also told that practicing privileges would not be renewed if there were any mandatory training modules that were incomplete.

Compliance for mandatory training for all staff, excluding medical staff, during the time of inspection was as follows: moving and handling 97%; food safety 100%; health and safety 97%; fire safety (level 2) 97%; manual handling 85%; basic life support 63%; infection control 83%, deprivation of liberty safeguards and mental capacity 90%; fire training 91% and first aid training 100%.

The service had identified key mandatory training subjects in accordance with relevant professional bodies regulations and in line with professional standards of practice. This included but was not restricted to the following professionals: General manager and head of rehabilitation, hospitality and deputy manager, neuropsychologists, physiotherapists, occupational therapists, speech and language therapists, rehabilitation and healthcare assistants, interpreter, drivers and senior management team.

Mandatory training for members of staff with the exclusion of consultants was delivered as a mix between in-house and external training. During our inspection the service met the training target for non-medical staff in seven out of ten eligible training modules. The lowest training compliance rate for non-clinical staff was basic life support with 63% compliance. For medical staff the lowest compliance rate was for resuscitation with 50% compliance. This may lead to staff not being up to date with best practice in case of emergencies.

Community health inpatient services

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

The service had comprehensive adult and child safeguarding policies that were known to staff and accessible as electronic and hard copies on the premises. The service had a safeguarding lead and staff we spoke to knew how to contact them. There was a clear pathway to escalate safeguarding issues within the service's organisation.

The service used a multidisciplinary team approach towards the safeguarding of patients. Arrangements to safeguard adults and children from abuse and neglect were reflected in the services' practices and were in line with legislation and local requirements. We saw evidence of staff using patient notes and multidisciplinary team meetings to communicate and learn from potential safeguarding issues.

Compliance for adult and children safeguarding training for all staff during the time of inspection was as follows: safeguarding adults (level 2) 80% and safeguarding children (level 2) 94%.

During our inspection the service did not meet the training target for safeguarding in adults. However, staff understood their responsibilities and adhered to safeguarding policies and procedures. This included working with other agencies such as social services. As an example, when staff suspected of a safeguarding issue they raised it to the safeguarding lead and then to the local authority safeguarding team. They received information and were advised as to what best procedures to put in place and followed recommendations.

We were told that adult safeguarding training was delivered in-house. We were assured that staff who were non-compliant with training would be invited to the next training session. We were shown a list of staff requiring training and were told by staff that in case of any doubts they would liaise with the safeguarding lead for the service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff followed effective systems and processes to prevent and protect people from healthcare associated infections. There were regular and appropriate checks in place to ensure standards were maintained.

The service employed an infection control nurse who was responsible for implementing practices and developing processes for safeguarding systems for cleanliness infection control and prevention (IPC). The IPC nurse was present at the service at least once a week to advise, train and supervise auditing of IPC practice.

The service identified and carried out risk assessments for patients and a full screen test for contaminants on admission and when needs where identified. Microbiology testing and advice was available as part of a service level agreement with a private hospital.

The service provided appropriate and adequate quantities of personal protective equipment (PPE) for example, gloves and aprons in a range of sizes. These were available across the service for easy access and were identified appropriately. The service was meeting standards set out by the Centre for Disease Control and Prevention 'Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare Settings'. This states: "PPE must fit the individual user, and it is up to the employer to ensure that all PPE are available in sizes appropriate for the workforce that must be protected." There was also easy and constant access to hand alcohol gel and cleaning soap.

During our inspection, we saw staff regularly using hand washing facilities and following the World Health Organisation 'Five Moments for Hand Hygiene' guidelines. We observed all staff were bare below the elbows and sinks across the service had posters advising people of the most effective methods of handwashing.

The service did not comply with health building notes (HBN) regulations 00-09: Infection control in the built environment. This is because there was no sluice located within the services' rented premises. However, there was an available sluice located in the landlords premises and it was available to the service. We saw evidence this issue had been raised and addressed with the use of an IPC risk assessment in the services' risk register.. The assessment identified a significant risk of contamination if the

disposal of human waste and other potentially infectious material was carried from one service to another crossing areas such as the living room and by having stop periods to open service doors to access the sluice on the opposite side of the building. As such, it was actioned and implemented that best clinical practice to lessen the risk of infection was to use disposable toileting equipment such as vomit bowls and cardboard urinals. Human waste was disposed in the ensuite toilets of the patient and the used disposable equipment was consigned to appropriate waste bags. For the remaining reusable equipment, the service used sanitizer wipes and in cases of higher infection risk a chlorine solution to wash the equipment. The service also identified a designated toilet for the storage of reusable equipment such as commodes and bath chairs. This toilet was not used for other purposes. We were assured that the solutions adopted by the service were effective and safe.

We checked equipment throughout the service and found items had 'I am clean' stickers on them to indicate they were ready for the next patient to use. Stickers and cleaning equipment were adequately stocked and stored in equipment storage locations, therapy rooms and near the nurse's station.

The service had a service level agreement with the landlord where they used their cleaning staff to maintain hygiene and cleanliness of the rooms, therapy rooms and premises of the service. The service level agreement ensured a dedicated cleaning member of staff which had training in infection control and an induction to trolley use. Cleaning record sheets were completed daily. As part of the service level agreement the service had access to all cleaning records. To ensure standards were maintained, a second review to challenge these records was conducted if the cleaning standards were not deemed appropriate by the hospitality team. We saw evidence of this system being used and examples of how challenges were escalated through the use of photos and written reports to the cleaning team.

Staff across the service understood and could explain isolation processes such as the use of shut doors, display signage, facilities information, presence of decontamination trollies outside patient rooms, and increased family awareness towards IPC. This was in line with current IPC regulation.

The service had an effective system to manage waste disposal with correct disposal of black bags yellow bags, red bags and gloves and aprons. This was in line with the Health Technical Memorandum 07-01: Safe management of healthcare waste. Staff had easy access to a biohazard spill kit and a urine, vomit and blood spill kit. We spoke to the landlords' housekeeping manager who explained how housekeeping staff and healthcare assistants were trained in how to use and manage waste correctly.

The service managed laundry in an effective way to minimise infection. The service used different coloured bags to identify laundry that could be managed in-house and laundry that would have to be cleaned through an external cleaning agency should it contain contaminants or be of high infection risk. An example of this was that if any clothes or linen were soiled these would be stored in the appropriate bags and sent off site for deep clean. Clothes and linen that did not present an immediate infection risk was washed using the in-house laundry room. Access to the laundry room was through a door in, door out system.

The service identified and carried out risk assessments for newly admitted patients and a full screen test for contaminants. Part of the isolation process involved the use of a mobile clinical sink as there were no clinical basins in the patients' bedrooms. We were assured that staff were familiar with this piece of equipment because nurses and healthcare assistants explained how this was managed to minimise infection and contamination risk.

The hospitality team audited cleanliness at regular intervals in line with the national specifications of cleanliness guidelines. These state: "Very high risk areas should be audited weekly and achieve a score of 98%, high risk areas should be audited monthly and achieve a score of 95%. Areas of significant risk should be audited 3 monthly and score 85% and low risk should be audited 6 monthly". We saw records which indicated targets were met following audit. We saw this information was recorded in the annual infection control report.

We reviewed three cleaning logs for therapy rooms which showed evidence of daily cleaning. We saw evidence of waste bins being collected two to three times a day and resident patients' bedrooms being cleaned daily. The service told us that if a bedroom was not in use it would

be cleaned and dusted two to three times a week. All the ward cleanliness audits met national standards. We checked four cleaning schedules and found them to be completed and signed off.

The service offered a deep clean to each room prior to admission and following discharge. This was part of the IPC policy. Curtains were taken down and steamed while the bedroom floor, mattresses and bathrooms were chlorine washed. We were told patients could request their room to be cleaned at any time should they feel it was not up to their standards.

Across the service sharps bins were correctly assembled and labelled to ensure traceability. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations).

Environment and equipment

Staff had access to adequate, well maintained equipment to perform their jobs. The service did not own the locations it provided services from, but the environment and estate was not a challenge to maintain.

The service had well established policies around safety and safeguarding systems regarding the use of the environment and any therapy and diagnostic equipment. This included equipment manuals and record logs. Training regarding practices and use of environment and equipment was easily accessible and communicated at an effective level.

We checked therapy and diagnostic equipment across the service and found devices were all serviced, tested and labelled according to electrical safety and provider guidelines. Equipment storage was well organised, well-stocked and clean and dirty equipment were segregated appropriately. Equipment was tagged with "I am clean" stickers with the date they had been cleaned. We saw sanitiser gel and disinfectant wipes were readily available in the storage cupboards within each therapy room.

We saw the main storage room on the ground floor was clean and organised with all equipment stored within clear plastic boxes. These were labelled and there was a log book to maintain account of used equipment. This storage room also contained two fridges, one for specimens and another for medication. These were easily accessible and clean. However, there were boxes of disposable hygiene equipment on the floor which made it difficult to access the lower shelves. This equipment was still inside the original boxes and was wrapped in plastic.

Patients across the service who were at increased risk of pressure damage were provided with alternating airflow pressure mattresses to reduce the risk. Electric beds were used for patients to enable them to change their position with relative ease and to higher or lower the beds before standing.

The service appeared clean and organised and there was a service level agreement for the use of the premises. Staff felt they could escalate issues to the facilities manager. These were addressed with flexibility to address patients' needs. An example of this was a patient who needed their bedroom mirror to be lowered so that they could wash and dress independently. This was done immediately for them.

The service was split into four levels. Therapy rooms and the hydrotherapy pool were on the ground level. Bedrooms, dayroom and nurses station as well as linen and equipment cupboards were located on the first floor and step down residential rooms and therapy and managers offices were located on third level. Access to the different levels could be made via lift or stairs with two different lifts available. The service could also make use of a cinema room, occupational therapy kitchen and rehabilitation gym located in the basement.

People were kept safe by design and maintenance of the premises. Access to the service was made through a front door buzzer system and access granted to a main reception area. Access to the remaining levels was done through two action mechanism using a push button and door handle system. Therapy rooms, storage rooms and kitchen areas were accessible with the use of a key safe. Staff had access to the key safe numbers through a central system. The garden area was private and secured and access was supervised by staff.

The service had fire extinguishers which had up-to-date servicing. Staff were aware of fire safety policies and evacuation procedures. Emergency evacuation chairs and sledges were available for emergency situations where the lift could not be operated in the case of an emergency. A fire alarm test was completed weekly and a

check round for doors with three visuals and a power off test conducted each month. Service engineers were responsible for elevator maintenance although the maintenance team was trained for elevator release.

The service had a resuscitation bag available at the nurses' station. We saw evidence that it was stock checked daily. Staff were aware of the location of the resuscitation bag and knew how to escalate any emergencies as per service policy.

Linen and storage cupboards were organised and clean. Staff also had access to bed linen in the patients' bedroom. These were in the wardrobe in a sealed box.

There was a service level agreement with the landlord so that waste and clinical specimens could be managed in a safe way. Staff ensured that offensive material was classified and segregated appropriately. There were also effective management strategies to store, label and handle waste within the building. However, the outdoors clinical waste compound was not locked and secured and bins were also unlocked. This was in contravention of the Health Technical Memorandum 07-01: Safe management of healthcare waste.

The service used a hydrotherapy pool. Estates managed the pool maintenance and monitoring as per service level agreement. This was completed at the beginning and end of each day. If the pool was in use, three readings were completed daily within an hour and a half prior to each session. We saw evidence of weekly specimen samples being taken. There was a policy that ensured that if there was contamination the pool would be shut and a super chlorination would be completed. We also saw evidence that the service used an external regulator to keep up to date with changes to regulations and most recent pool maintenance evidence.

There was a maintenance log which was reviewed daily by the estates manager for the reporting of any defects or maintenance requirements. Staff told us any issues raised were dealt with immediately.

Assessing and responding to patient risk

We found a wide range of risk assessments, screening tools and record charts that were used to minimize risk to patients. Effective policies and procedures were in place to manage a patient in an emergency. There was a strong emphasis on multidisciplinary assessments and weekly reviews to continually monitor and identify patients at risk. We saw evidence of the use of in-service training to make all staff aware of potential risks and to know who to talk to when an issue arises.

The service developed patient risk management plans in line with national guidance and policies that identify how to respond to patient risk and how to assess this risk to the team. The service had escalation policies and procedures in place for deteriorating patients and they were used effectively. Any urgent medical needs were assessed via the on-call consultants or 999 was dialled and patient transfers made to acute hospitals as necessary.

We saw appropriate mitigation of the risk of pressure damage to patients' skin. A risk assessment based on a nationally recognised assessment tool was used to determine the extent to which each patient was at risk of pressure damage. The service had access to a tissue viability nurse who was on-call should any patients require assessments or if a risk of developing an injury was present. The tissue viability nurse's role was to prevent insults to the skin and underlying tissues and promote healing in wounds where a complication had prevented the normal healing process to occur. We were told that in addition to the standard assessments the nurse also used doppler scanning to identify any secondary issues should these not be accountable through standard assessments. The tissue viability nurse had verbal and written communication with the resident medical officer, consultants and staff. We were told that any urgent cases were highlighted immediately to the multidisciplinary team and that assessment information was always communicated whether results were positive or negative. Where the patient had an increased risk, their care plan included the action to reduce the risk. Preventative measures included specialist alternating air mattresses for those at highest risk, pressure relieving cushions and profiling mattresses. The unit promoted a focus on rehabilitation and encouraging mobility which was the most effective means of preventing pressure damage.

Patients observations were used to calculate a National Early Warning Score (NEWS). This is a nationally recognised system of using key observations such as the patient's blood pressure and pulse to help staff recognise changes in a patient's condition that might indicate a

deterioration in their health. The service adjusted this system to better address the needs of neurological rehabilitation patients. This service also included steps on how to call a doctor or consultant if there was an emergency and identifying what actions to take and how to report any changes in patients condition should there be a deterioration in the patients' health.

Staff completed a falls risk assessment for patients on admission and were reassessed throughout their rehabilitation period. Staff were informed of the patients falls risk through handovers and multidisciplinary meetings and actions were immediately put in place to address the patients falls risk. For example, the service used pressure sensitive mats that would alert staff if a patient were to get out of bed or off a chair unsupervised. Additionally, patients with the greatest falls risk were accommodated close to the nurse's station so any needs or calls could be tended to quickly.

Staff told us they felt comfortable seeking advice from senior staff in cases of a patient presenting with deteriorating health and well-being. Staff also had specialist training around identifying challenging behaviour and had the support of clinical psychology should any behaviour challenges occur.

Staffing

The service identified staffing levels and skill mix on a patient needs basis. We were shown how there was a core team of staff who worked permanently for the service and included one resident medical officer, three physiotherapists, two occupational therapists, three speech and language therapists, two rehabilitation assistants, one nurse, two clinical psychologists, three healthcare assistants one dietician and one interpreter.

When patients care needs were identified as requiring more input or more clinical support the service could address these needs by using the service level agreement with the landlord to access nurses and healthcare assistants. If the therapy team required more staff to support patient needs they would resort to the use of bank or agency staff. At the time of inspection the service had one physiotherapist, four nurses and one psychology assistant as bank members.

On inspection, staffing levels and skill mix were within planned levels and there was cover provided for absent staff. As per the service level agreement the provision of additional nurses and healthcare assistants met the needs established by the service. This was identified as one healthcare assistant for every three patients and one nurse for every five patients. We saw the staff rota and found it was fully covered for the day of inspection. We also saw the nurses' rota for the previous month and no gaps were identified.

The resident medical officer was available within working hours from Monday to Friday and half a day on Saturday. Out of hours cover was provided by consultants via telephone. The consultant would come in to the service should they be required. Sundays and bank holidays were covered using the on-call consultant system. The service identified a nominated consultant should the patients' allocated consultant not be available.

The services' rehabilitation team had access to physiotherapy, occupational therapy, speech and language therapy, dietitian and clinical psychology. The service also had access to a permanent interpreter.

Arrangements for the use of bank agency and locum staff kept people safe. This was because there was a handover system as well as an induction for all temporary staff. Additionally, the service identified a core group of bank and locum staff who would support cover for any of the therapy team members should they be unable to perform their duties. This ensured that bank and agency staff knew the services' culture and standard operational procedures as well as facilitating rapid integration within the multidisciplinary team.

The services' handovers and shift changes ensured people were safe. Handovers and shift changes were completed twice a day with an allocated handover time. We were told if a patient had changes to their mobility plans or an updated activities risk assessment or if new needs were identified by the team they would liaise with the nurses and other elements of the therapy team and present or write a new care plan during handover. The quality of handovers and service changes was a standing item in weekly team meetings and was discussed as part of the patients case management. This ensured the service safely implement changes to patient care and maintained safe standards of handover care.

Quality of Records

People's individual care records were managed in an effective and structured way. The service used a single

patient record which meant there was one place for staff to access information. This facilitated and promoted good communication and record keeping. Patient records also showed good multidisciplinary team working. Therapists and nursing staff contributed to and shared information on patient care.

We found medical notes were organised and information was accurately divided into professional relevant notes. There was one uniform document that contained all relevant patient information. Patients notes were safely stored in a locked cabinet in the nurses' station.

We reviewed five patient records which showed all treatments offered and all information needed to deliver safe and personalised care. In the patient notes we saw that consent and patient involvement was always documented. The records we viewed reflected the care we observed being delivered.

We saw evidence of audits being regularly completed to ensure care records complied with services standards. Outcomes of these audits identified areas in which to improve. One of these areas was the consultants input. The service actioned that consultants should write their notes or instruct the resident medical officer as to what to write during intervention or immediately after their intervention. This action point was a standing item in governance meetings and ensured monitoring could be maintained and outcomed.

Of the five patient notes we saw all had up-to-date information and completed do not resuscitate questionnaires. Patient assessments were completed, dated and signed off and everything including medication management and patient risk assessments were up-to-date with no missing information.

We were told if a patient became medically unwell they would be transferred to an acute hospital. There was a policy detailing the escalation of emergencies. It was the responsibility of the resident medical officer and nurse to complete all handovers and communicate with the hospital regarding medical conditions, medication treatment and provide a background history for the patient. The service provided evidence of when such transfers of care were completed and indicated that they would establish regular communications with the hospital once the patient was admitted.

The service had effective strategies and systems to manage information about people who used the services. We were given an example of an international patient who required a rehabilitation report on short notice to continue with treatment. Because records were kept up to date and were organised this was produced in a timely manner and the patient assured of their continuation with rehabilitation.

Medicines

We found medicines were stored and managed in line with best practise guidelines and legislation.

The service had an agreement with a pharmacy chain for a pharmacist to supply medication, review medication administration record (MAR) charts and support the resident medical officer regarding prescriptions. The pharmacist was also responsible for stock check and two-week block expiry as well as re-prescriptions.

The pharmacist was available on call but did a once a week visit to the service. It was the pharmacist's responsibility to look at drug charts, check the accuracy of the MAR charts, look for interactions and liaise with the lead nurse and resident medical officer if any medication was missed thus ensuring clinical accuracy. We saw evidence that patients received appropriate therapeutic drug and physical health monitoring in line with national guidance. Nurses were informed of medication changes through handovers or direct liaison with the pharmacist or resident medical officer. All changes were recorded and dated accurately on patients notes.

The pharmacist together with the lead nurse and resident medical officer were responsible to do a "medication use debrief" for patients being discharged from the service or when patients requested more information about the medication they were taking. This debrief addressed topics such as changes to prescription and associated side effects.

We were informed that if a patient was alert and conscious and had mental capacity all medication was explained to them and information provided about manging medication safely. If patients did not present mental capacity staff would liaise with the family or in line with the mental Capacity Act 2015 and all relevant decisions were documented.

Staff managed the medication trolley appropriately and it was stocked with non prescription medication should

patients request them. We saw medication distribution record sheets were completed accurately and emergency drugs were within date. We saw the medication trolley was securely locked when nurses were administering medications as well as when the trolley was not in use.

Patients who were identified as being able to administer their own medication were screened and provided with medication which was stored in an appropriate and single patient accessible storage cupboard in the patients bedroom.

The service ensured people received their medicines as intended with the use of the MAR chart and patient records. We saw evidence this was appropriately recorded for all patients. There was also a home remedy list which was monitored and highlighted as part of the daily handover from nurses. We were told if there was an excessive use of home remedies these were reviewed by the pharmacist and lead nurse, the resident medical officer would be alerted and medication transferred to prescription should this be the ideal course of action.

Safety alerts regarding medication were highlighted as needed and brought in to the service through the pharmacist. The service operated within current national guidance as there was an appraisal process for the resident medical officer.

The service informed patients' GP's of any changes to medication and told them if any re-prescribing was necessary.

We were told overseas patients would request health funding through the embassy for provision of medication. On discharge if the patient was on any medication that was unavailable in their home country it would be amended to find an equivalent medication. The service dispensed 2 months' worth of medication through the embassy.

The service ensured safe management of medication intake by using two professional guidelines for patients with swallowing difficulties or who were being fed through a percutaneous endoscopic gastrostomy (PEG) feeding tube. We were also told the pharmacist delivered emergency antibiotics and liaised with the speech and language therapist when considering medication intake for patients with swallowing difficulties.

During the inspection we checked the refrigerator used to store medicines. It was monitored daily to ensure that temperatures were within the safe range. We saw records of this were completed daily and staff could describe the escalation processes if the temperature was outside the safe range. This meant that medicines were always stored in line with manufacturer's guidelines.

Incident reporting, learning and improvement

Staff understood their responsibilities to raise concerns regarding safety incidents and near misses. These were reported internally and externally where appropriate. Managers investigated incidents thoroughly and shared learning from lessons across the service.

Staff we spoke to understood the term duty of candour and its meaning in practice and could give examples of when it had been applied. The duty of candour is a regulatory duty that 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.

We saw the service's incident reporting log. This was used by staff on an individual basis as well as in multidisciplinary meetings to record incidents. Staff believed the use of the incident log in multidisciplinary meetings encouraged openness and honesty and learning from shared experiences.

The service had a policy for incidents as well as a learning dissemination strategy. The heads of therapy or nursing were responsible for the completion of the accident and incident form. This would then be reviewed by the service manager.

As part of the learning experience from incidents the team was having root cause analysis training sessions when an incident was reported encouraging active learning. The heads of department were responsible for this and for disseminating learning within their teams. Any incidents requiring immediate escalation would be brought to the attention of the service manager and human resources who would use the service's incident policy guidelines to respond appropriately.

We were given an example of an incident were there was an unexpected early discharge from the service and the learning that came from it. The team analysed the patient's journey through the service and identified areas

where they should have been more prepared in case patients finish their rehabilitation earlier due to unforeseen circumstances. This has led to the staff being encouraged and supported to have all assessments complete within time and start preparing discharges from an earlier stage of rehabilitation.

Safety performance

The service was informed about patient safety by a series of safety monitoring information including safety thermometer indicators such as the occurrence of pressure ulcers, patient falls, catheter acquired urinary tract infections and venous thromboembolism (VTE).

The service had a risk assessment for falls which was multidisciplinary informed. Countermeasures if a risk was identified included the use of sensor mats, hourly checks and relocating high falls risk patients nearer to the nurses' station. These patients were also offered one to one support during their activities of daily living.

The service had other safety performance assessments such as their "core values assessment". This assessment was aimed at identifying basic needs for patients such as level of independence and maintaining their dignity. As an example, part of this assessment identified whether a patient could use a call bell. If the patient was unable to use it this was identified as an action for the multidisciplinary team to address. We were given an example of a patient who was not able to use the call bell but following a multidisciplinary assessment was found to be able to use a regular bell to call people's attention. This was then documented as part of the patient's rehabilitation plan and acknowledged by all members of staff.

We were told that when patients accessed the garden and other open areas in the premises those who could use communication equipment could use a walkie-talkie for assurance if they lacked confidence. However, to promote equal access opportunities and manage risk for a larger number of patients the service was procuring a system of pendant alarms to substitute this practice.

For overseas patients there was a period of isolation where an extensive risk assessment was conducted this includes the testing for methicillin-resistant Staphylococcus aureus (MRSA) and carbapenemase-producing enterobacteriaceae (CPE). Other assessments included a catheter infection control audit which as a result encouraged fluid intake and the monitoring of vital signs. If a urinary tract infection was detected the consultant was notified and samples sent to be tested as urgent.

As per inspection records during the period of January 2017 and December 2017 there were a total of nine non-clinical incidents relating to trips and falls. These non-clinical incidents were taken on as learning events for the team. During this period the service didn't have any serious clinical incidents.

Are community health inpatient services effective?

(for example, treatment is effective)

Outstanding ☆

Evidence based care and treatment

People's physical, mental health and social needs were assessed as a whole. Staff delivered care in line with best practise and the national institute for clinical excellence (NICE) guidelines. We saw evidence managers and head therapists updated policies when national guidelines were updated.

We were told how the use of the national stroke strategy and NICE guidelines for long term conditions was key in developing services that were in line with the services identity "Doing living rather than doing rehab". Examples of this were the development of services such as the spasticity clinic and the use of interdisciplinary working to promote patients' independence.

The service explained to us that the use of clinical guidelines also promoted the services' investment in new technology and innovative treatments such as a robot assisted automated treadmill and a self initiating arm and hand therapy rehabilitation exercise device. This technology and equipment was used to enhance the delivery of effective care to service users and increase therapy input. The use of this technology also provided statistical and data analytics to support the development of evidence around the use of this technology.

All therapy teams could demonstrate how they used clinical guidelines and evidence based practice to develop their interventions. As an example the spasticity

clinic used gold star practice guidelines such as the use of ultrasound to guide injections and the measurement of muscular activity through electrical current to provide the most individualised and appropriate intervention for the patient. The use of clinical guidelines and evidence based practice was an example of excellent interdisciplinary working as it ensured the whole team was consulted with regards to goals, treatment and management of the rehabilitation intervention.

The service had processes in place to ensure no discrimination was made when providing care and treatment decisions. This was upheld by individualised and detailed personalised care plans which were patient focussed, maintained up-to-date and developed in line with relevant good practice and clinical guidance.

The service promoted a transdisciplinary model of care. A transdisciplinary model of care enables different professions to work jointly to create an integrated and beyond discipline specific approach to address a common problem. Staff felt encouraged by this model as it allowed them to think of innovative and different ways that they could use each professions expertise to develop a therapy plan with a patient centred approach. Staff and the service encouraged this practice as it promoted continuity of care, an improved approach to managing challenging behaviour, supported a functional platform to work on goals, helped manage cultural expectations and spiritual needs and supported families and social networks to work as a whole.

Staff demonstrated that the Mental Health Act code of practice was a key part of their practice and were aware of the rights of people highlighted in the Mental Health Act 1983. Staff identified concerns early and made timely referrals to appropriately trained staff who then carried out an assessment of the patients mental. An example given was that of a patient presented with emotional and cognitive difficulties were a referral to the clinical psychologist would be made to assess and support the patient. The multidisciplinary team would then create an individualised care needs plan in line with best practise.

Staff also showed awareness of when people needed to be told about seeking further help and advice and what to do if their condition deteriorated. This was done based on national guidelines and in line with best practice established by the service.

Staff used in-service training as an opportunity to explore new evidence and innovative practices that could benefit patients' outcomes as well as their personal and team development needs. We saw evidence of this in a presentation the service made about a patients journey through the service and how his needs led to the development of in-service training regarding feeding as a holistic rehabilitation approach.

We saw staff had access to trust policies and procedures. Staff we spoke with could access the intranet and showed were physical copies of policies were kept. If they could not find a policy they would escalate it to their head of team or with the service manager. Policies we reviewed gave reference to national guidelines and best practise and were within date.

The service was a part of accreditation schemes such as the Comparative Health Knowledge Systems accreditation. This allowed the service to have a benchmarking system against large healthcare providers and to develop their practice in line with new treatment evidence that is disseminated through this channel.

Nutrition and hydration

People's nutrition and hydration needs were being met, identified and monitored. We saw Malnutrition Universal Screening Tools (MUSTs) were fully complete and updated regularly. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese and included management guidelines which could be used to develop a care plan.

Patients had access to a dietician, speech and language therapist and a hospitality team to assist them with their nutrition and hydration needs. This was in line with national guidelines and best evidence practice. We also saw staff monitored patients nutritional input and offered drinks regularly.

The service offered a personalised management care plan which included assuring that food and drinks went from the kitchen to the right patients. The hospitality team were responsible for taking meal orders from the patients and delivering the meals to the patients. This meant patients had their meals explained to them and non-communicative patients were supported to make their choices known. The hospitality team also ensured that dietary requirements such as modified consistency diets, diabetic meals or if feeding assistance was required

was correct for the patient. These needs were primarily identified by the multidisciplinary rehabilitation team and then communicated to the hospitality team through handover sheets to guarantee that the right patients had their needs attended to in the right way.

We saw the menu had a large variety of options with several dietary choices sensitive to cultural and religious requirements. The menu was delivered in several languages however due to the vast choices available it was not communication friendly. The service had identified this as an issue and a draught picture menu was being developed. We were told this issue was also addressed by using the hospitality team to take meal orders.

There was joint work between speech and language therapists and the dietitian to develop nutritional and hydration plans as well as taking into consideration patients' needs. As an example, the service identified that patients were putting on too much weight during their stay. This was communicated to the hospitality team and the menu was restructured with the help of the kitchen staff to deliver a menu that would provide for less caloric intake whilst maintaining nutritional levels. The service also developed educational sessions for family and friends regarding people's nutrition and hydration needs, as well as addressing what types of snacks and food being brought into the service were suitable for the patients.

The service developed other areas within nutrition and hydration to promote patients independence such as the use of meal mats and the assessment of the safe use cutlery. As part of the individualised care plan the multidisciplinary team was responsible for continuously assessing and encouraging patients to lead as independent lifestyles as possible. This was addressed using therapy sessions aimed at feeding as well as the assessment of adapted cutlery.

Pain relief

Patients were supported with their pain management as part of their care and rehabilitation plan. Clinical ward rounds used patient feedback to document pain or pain instigating activities through visual analogue pain scales.

Patients who experienced pain where regularly discussed within multidisciplinary team meetings. Profession specific skills regarding pain assessment and management were used to address issues and identify best pain management practice. We saw evidence of this during a multidisciplinary team meeting were feedback was documented in the patient's notes and strategies regarding the patient's pain management were highlighted in a distribution list so that staff were aware of the patients' needs.

Patients felt comfortable to discuss their pain with any member of staff. Staff told us if a patient was in pain they would escalate this to the lead nurse. We saw 'as needed' pain relief was readily available to patients. Pain assessments were documented and patients who were requesting "as needed" pain medication would regularly be re-assessed by the resident medical officer and put on prescription if this was more appropriate pain management.

Staff were alerted regarding any changes in pain management and if pain management was needed to better tolerate therapy sessions. We were given an example of this when pain medication was given 40 minutes before treatment to improve tolerance to exercise in therapy sessions.

We found pain scores were documented regularly and it was clear that "as needed" pain relief was given in response to an increase in the patients reported pain score.

Patient outcomes

Therapy staff measured patient outcomes using a variety of well-known validated tools to assess the impact of treatment interventions. Patients were supported, where possible, to return to their previous level of independence through joint goal setting.

Patients' care and treatment outcomes were routinely collected and monitored. There was a clear approach to monitoring, auditing and benchmarking the quality of those outcomes for the people receiving care. We saw evidence of the use of audits to ensure that data was being collected in a timely and consistent way

The service showed that people's needs were being met using qualitative and quantitative information. This was visible in patients notes where the service was using the Goal Attainment Scale (GAS) for person centred goals and the Functional Independence Measurement/ Functional Assessment Measurement (FIM/FAM) assessment for a multidisciplinary patient centred approach to care. The

service also addressed patients' quality of life with the use of the satisfaction and quality of life 9 questionnaire (SQOL9) and customer satisfaction questionnaires. We saw in patients' notes and multidisciplinary team meetings that each patient's individual goals were being appropriately identified and achieved. We also saw that staff were providing the appropriate rehabilitation and care so patients could achieve their goals within agreed timeframes.

The service was part of several accreditation schemes which supported benchmarking of their results. The service also participated in research and trials such as the use of the robot assisted automated treadmill and the self initiating arm and hand therapy rehabilitation exercise device.

The service used information collected from outcome measures and GAS goals to improve therapy provided to patients. We saw an example of this during the multidisciplinary team meeting were the patient's outcomes were used to develop the treatment plan and set rehabilitation pathways such as access to kitchen assessments. We also saw evidence of all members of staff participating and being involved in activities to monitor and use information to improve outcomes for the service.

The service also used patient outcomes to monitor and establish rehabilitation timelines. This improved the efficiency of the team as well as supported patients to identify their rehabilitation needs. Staff had access to all patient outcomes and notes and had open and honest communications with the patient and family members when identifying if goals were still achievable or being met.

Patients were supported with a home discharge programme in line with their desired goals and outcomes. This included exercise programmes, advice for the patient and family members regarding the use of equipment and explaining how the patient would need support or encouragement to manage their long term condition over time.

The service communicated goals and outcomes with other partners such as social services when developing care plans and with community rehabilitation teams when these would be continuing patients' care when discharged from the service. This communication was sent through the home discharge programme as well as through a discharge letter explaining intervention and outcomes the patient had achieved and was aiming to achieve. The service had identified some concerns with overseas patients' outcome communications and carryover when being discharged. They found this was due to cultural implications. The service and staff tried to be proactive in providing a discharge package which went with the patient and included goals and rehabilitation aims that could be met abroad. This also included support for care staff and advice relating to the patients well being and self-management.

Competent staff

We saw staff were competent to perform their roles, attended regular supervision and training and had regular appraisals. Leadership development training was available to staff, which was encouraged by managers. We saw evidence that there was a 100% appraisal completion rate for consultants, nurses, carers and therapy staff.

Staff assessed patients' needs and preferences using the right skills and knowledge. The service encouraged staff to continue their learning in line with best evidence and patient needs. The service also identified the learning needs for professional groups as well as multidisciplinary team needs.

The service provided an induction to all newly recruited staff. To ensure staff had the appropriate skills and competencies they were assessed by the team during a probation period to identify if staff had the appropriate skill set to work for the team.

The service identified staff learning needs through an appraisal scheme as well as personal development plans. The services' line management system supported junior staff in identifying their training needs as well as supporting more senior staff to receive supervision and appraisals through internal and external sources. We talked to one of the heads of therapy who said they received leadership supervision through their service manager and clinical supervision through an external supervisor.

Staff we spoke to said they felt encouraged and were given opportunities to develop their professional practice. Learning was provided through a mix of in-service training, multidisciplinary shared learning

experiences and external training such as conferences, training days and university modules. Training covered the scope of work and was completed and achieved within protected time.

Staff said they had a variety of arrangements to support the delivery of effective care. This included one to one meetings, inter-professional meetings, multidisciplinary team meetings, appraisals and clinical supervision.

We were told that poor or variable staff performance would be identified and managed through the service manager as well as the head of therapy. Staff would be supported to improve performance through open discussions as well as identifying development needs in their appraisal programme. Other issues that may impact staff performance would be escalated as required through the heads of staff to the service manager and then executive team and dealt with in line with the services operational procedures.

Multidisciplinary working and coordinated care pathways

Multidisciplinary working supported effective care planning and the delivery of therapy for adults with long-term conditions and complex needs. All staff were involved in the service and organisation development as well as assessing, planning and delivering care and treatment. We saw evidence of this in the patients notes as well as the individual teams' performance audits.

We witnessed a multidisciplinary team meeting which was inclusive of all staff. Staff could challenge and ensure the patients' needs were fully discussed in a holistic and joined up way. Ongoing care, family and those close to them and their needs were also discussed. We saw arrangements for working with other providers to help plan and deliver care, treatment and support people in a holistic and joined up way. This was reinforced with patient centred goals and establishing completion dates and discharge timelines.

Care pathways facilitated the delivery and review of coordinated care between different teams, services and organisations. The service supported discharges and worked with community services through referrals as well as with social workers and social care providers.

Information was sent through when requested via reports and planned activities. Open communication between teams was established when patients needs needed to be met.

All team members were aware of their responsibility for each individual patient's care. This ensured that treatment was consistently delivered in a coordinated, person centred and supported way. This was evidenced in the patients care plan and notes and in the multidisciplinary team meeting we attended. We also noticed that all staff members knew who the patients using the service were and had knowledge of their needs and which professionals where involved in their care. We heard evidence of this when patients interacted with staff in the corridors and were asked how they were progressing with their rehabilitation goals or when they were due to have a session with a member of the therapy team.

The service informed all relevant teams, services and organisations about a person being discharged from the service when required and appropriate. Staff had direct liaison with the embassies for overseas patients and communication regarding treatment and discharge planning was delivered in an effective and timely manner. For other patients a discharge process involved liaison with social care services, therapy teams and families and individuals who may care for the patient. We heard of examples of private and case management patients where the discharge process was coordinated with other services to ensure coordinated care and to develop a stable support network when the patient was discharged.

Health promotion

Staff spent time with patients when they were admitted to the service to explain the process of their rehabilitation and agree expectations. We saw patients were fully involved setting their goals which meant they were realistic and achievable. We also saw staff took time to understand patients' lifestyle prior to admission and where appropriate went to lengths to ensure patients could achieve their previous potential.

The service identified patients who needed extra support such as people who would need stop smoking advice or had dietary requirements. The team supported carers as well as people who lived with the patients identifying what to expect and how to support the management of long-term conditions. As an example, the speech and

language therapist supported people with communication needs and how they may address these in a community setting. We also heard of how the team worked together on identifying best strategies to promote healthy eating within the service.

Patients were involved in regular monitoring of their health and were educated as to what signs to identify when they required further support. This education was done during therapy sessions as well as using booklets and intervention days. We saw the service worked alongside the NHS calendar for national campaigns agenda providing education around topics such as allergies, healthy eating, dementia and cognitive difficulties. We also saw that the service provided support in improving patients' health by providing information about smoking cessation and obesity.

We saw the assessment of patients on admission identified if any additional support was required to promote healthy living or changes to life-style. This was discussed at the multidisciplinary team meetings so that appropriate support could be offered. Staff documented changes or any additional needs clearly. This ensured that options were discussed with the patient and that staff, patients and their carers followed up the patients' evolution.

Consent, Mental Capacity Act and deprivation of liberties

Staff had a good understanding of the Mental Capacity Act, 2005 and there were good systems in place to assess a patient's capacity to make decisions about their care. We saw documentation was completed when these assessments were carried out.

Staff understood the importance of consent and decision-making requirements. We saw evidence that consent forms were completed for all patients regarding the provision of care. We saw staff always asked for consent prior to any intervention with the patient.

The service had a policy relating to mental capacity and this was included in the induction pack. This policy supported staff when making decisions and was in line with relevant legislation and clinical guidance.

The service had a nominated safeguarding lead who was responsible for supporting staff should they feel unable to manage any issues. We were told the service used and reviewed changes to capacity and monitoring through multidisciplinary reviews as well as addressing capacity issues throughout the progress of rehabilitation.

We were told patients who lacked mental capacity were regularly assessed and outcomes recorded. Decisions would be made in line with local policy which identified that if a person lacked mental capacity a decision made in best interest would be discussed with the next of kin and family when possible or a decision about care was provided in line with best evidence and clinical guidelines when this was not possible. Additionally, the service had support from the clinical psychologist to back any best interest decisions as well as ensuring the patient received the right care at the right place.

Staff recorded consent for treatment and decision-making in the patients' care plans. This was regularly monitored and reviewed meeting legal requirements and following governance recommendations. The service conducted regular audits and reviews to ensure consent was recorded.

The service promoted a supportive practice to avoid the need for physical restraint. This was achieved through one to one personal care where needs were identified or allocating patients closer to the to the nurses' station should they require any additionally support.

Are community health inpatient services caring?

Outstanding ☆

Compassionate care

During the inspection we saw extensive and proactive engagement between staff and patients. Patients told us that they were encouraged to be as independent as possible by staff who provided appropriate assistance in a sensitive way.

Staff understood and incorporated the personal, cultural and social needs of patients into their care plans. Patients told us they felt that all the team knew what was happening with them and linked together to meet their

needs. We heard examples where patients were accompanied by therapists and care assistants to local social and religious events to support patients' needs and assist them to regain a sense of normality.

During the inspection we saw patients being treated with compassion and clearly enjoying their interaction with staff and other people present at the service. Interactions were respectful and considerate and staff demonstrated genuine interest in peoples' wellbeing.

We heard many examples of staff going "Above and beyond" in terms of caring and supporting patients. We heard of therapists doing social catch up calls to know how people were doing following discharge from the service. We also heard examples of staff joining patients in out of hours social activities and taking people on shopping and community visits to help them avoid feeling institutionalised.

Staff demonstrated they could identify situations were discriminatory, disrespectful or abusive behaviour might occur. They said they felt able to raise concerns about these issues should they occur.

Staff's culture of caring ensured peoples' privacy and dignity needs were understood and always respected. This included asking patients if they were well and needed anything during all interactions. Staff said they were would look for signs of a patient not feeling comfortable with an intervention and would ask the patient if there was anything they could do to make them feeling more respected and dignified.

Patients told us they always felt their dignity was prioritised over the needs of the service. We heard an example where a patient was self aware of their condition and the impact it may have on other people attending a group rehabilitation session. After asking to leave the patient was asked if they were feeling better and an individual session was arranged to continue with the programme on an individual basis.

All patients told us that care was excellent and staff treated them with respect. Patients felt that if they had any issues they could just talk to any member of staff and it would be escalated to the appropriate person. This included staff being empathetic when dealing with patients' pain as well as emotional distress.

Emotional support

We saw staff always considered carers and families emotional needs in addition to the patients' needs. Patients and families could access counselling services through the clinical psychology team. Staff were knowledgeable about managing patients' emotional well-being and also encouraging their social needs.

People were given appropriate and timely support and information to cope with their emotional care and treatment. Staff felt empowered to support patients and advise them how to find other support services when being discharged. Staff ensured people's emotional well-being was met and consistently monitored. Staff told us that they always asked patients how they felt at the beginning of any intervention and assured patients that if they did not feel well they could talk to them or to any other member of staff. Patients and families told us they trusted the members of staff with their life.

The multidisciplinary team encouraged and supported carers and family members to participate in the patients' rehabilitation plans and therapy sessions. This ensured that people involved emotionally with the patient had the right competencies to manage their care once returning home and also had the ability to identify situations that may lead to emotional support being needed.

Staff recognised the importance of emotional wellbeing in people living with long-term conditions. We saw a presentation in which a patients' journey through the service was discussed and how the interdisciplinary model of care was integral to their rehabilitation. This encouraged staff to consider the invisible aspects of patient care, such as their emotional needs, and was known as the "iceberg" model of care.

Staff supported patients during discharges and ensured that people were able to report issues to their local GP or to other emotional and psychological interest groups in the community. For all overseas patients and non English speaking patients the service created translated information packs so that people who would liaise with patients being discharged from the service would understand their needs for emotional support and well-being.

Outstanding ☆

Community health inpatient services

Understanding and involvement of patients and those close to them

Patients were at the centre of everything staff did, which was consistent across the service. Staff supported patients to manage their own health, care and wellbeing and to maximise their independence. Patients we spoke to said they felt they had a voice and that staff were always determined in supporting people to realise their potential.

We saw patients and their families were encouraged to attend family meetings. Staff worked to ensure patients, their carers and relatives understood and agreed with the treatment and treatment sessions. Staff told us these meetings also helped understand people's individual preferences and how to best deliver individualised tailored care that reflected the way the patient liked to be treated.

Patients we spoke to felt that staff communicated with them in an understanding and caring way. Patients told us they always understood what was happening around them and were part of the decision making process. They also felt that their family was given the chance and opportunity to participate and give their opinion as well.

Staff found appropriate and accessible ways to communicate with people. This could either be done face-to-face or with the use of communication platforms such as communication mats or via electronic tablets. Staff also used and developed information pamphlets as well as care plan pamphlets and leaflets to support people during the rehabilitation.

Patients told us that they felt empowered and supported during the whole process and that rehabilitation had a positive impact on their health and wellbeing. Patients told us that staff were always available and they could speak to anyone. One patient said they felt that nothing was too much for the team and any request was tended to so their needs would be met as soon as possible.

Staff identified that patients were at the centre of their therapy. This meant that they routinely involved people who use their services and those close to them in planning and making shared decisions. Patients and family members we spoke to felt that their views were always respected and listened to making them feel the centre of the whole rehabilitation process.

Staff had an inclusive attitude towards everyone that was part of the patients' rehabilitation. This included family members, carers and friends. Staff knew family members and treated them as important partners in the delivery of care. Staff where open to questions from family and carers and involved them in the patients care pathway.

Patients felt that their information was always protected and that their choices were shared according to their wishes. Staff said they would ask patients if the information being discussed during any intervention was understood and allowed time for patients to ask questions. Staff told us that sensitive information was only shared with consent form the patient.

Are community health inpatient services responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

Planning and delivering services which meet people's needs

The services provided reflected the needs of the population that accessed the service. We saw that people's individual needs and preferences were central to the delivery of tailored care for neurological patients. Where people's needs were not met the service had taken proactive steps to improve, develop and accommodate these needs.

The service provided engagement and involvement opportunities for patients and those close to them through day to day interaction, multidisciplinary meetings and by ensuring that management was always available to discuss any service issues with the patients and their families. The service was designed to ensure flexibility, choice and continuity of care for the patients.

The service received accreditations that identified it as a centre of excellence for the delivery of neurological rehabilitation. Examples included the Commission on Accreditation of Rehabilitation Facilities (CARF) for inpatient rehabilitation and accreditation from the Comparative Health Knowledges systems (CHKs).

Facilities and premises were appropriate for the services being delivered. Staff could make use of individual

therapy rooms or use of a rehabilitation gym. There was also an occupational therapy kitchen with appropriate equipment tailored to assist patients in developing their independence and regaining confidence in a safe and protected way.

There were ensuite inpatient bedrooms as well as two step down accommodations with bathroom and kitchen. These two rooms were used by more independent patients so they could have a safe set up that promoted independent living prior to community discharge but still have access to a level of assistance that would reassure their long term needs were addressed.

There was a clear admission criteria for patients. There was a pre-admission assessment pathway to ensure that patients referred to the service were appropriate and fulfilled the admissions criteria before starting rehabilitation. The pre-assessment was led by the service manager or by the healthcare professionals if required. The pre-admission assessment could involve meeting patients at their home or hospital prior to admission and for overseas patients liaising with the patients existing medical staff or embassy.

A permanent member of staff for interpretation services as most non-english speaking patients spoke Arabic. The service identified this as a necessity so patients could always express their needs and understand what was being said to them. If any other patients who did not speak english or arabic were admitted the service used an external agency for translation services.

We saw service cupboards stocked with items such as party items, plates, tea sets, religious objects and special linens to ensure that special occasions and religious festivals could be celebrated in keeping with the patients' expectations and needs. These were also used for special occasions such as birthdays and family celebrations or when a patient requested them for a special event.

Meeting the needs of people in vulnerable circumstances

There was a proactive approach to understanding the needs and preferences of different groups of people and to deliver care in a way that met needs in an accessible and equal way.

The service used multidisciplinary assessments to identify and meet the information and communication needs of people with a disability or sensory loss.

Assessments were recorded in the patient's care plan and highlighted and shared with all professionals involved in the patients care. The service had access to adapted communication systems such as communication mats and electronic tablets to support people to be able to communicate more effectively.

The service demonstrated they were compliant with the accessible information standard. Leaflets, consent forms and patient booklets were available in several languages and different sized writing. There were clear indications of the locations at which people were and staff were readily available to support patients if they could not read or understand something.

Patients were supported during referrals, transfers between services and discharges. The service consultants were responsible for greeting newly admitted patients. The team assigned to the patients' rehabilitation programme was also introduced as soon as possible as well as explaining their scope of practice and interventional roles.

We were told communication between services prior to admission was completed with the use of admission assessments so that vital information regarding the patients' needs and circumstances could be documented and kept in one place. This ensured all professionals involved in the care of a newly admitted patient could prepare and be responsive to their needs.

Staff supported and educated patients and carers during discharges through the provision of discharge information plans and discharge meetings. These plans and meetings addressed topics ranging from rehabilitation goals, communication strategies, identifying stages of fatigue, acknowledging limitations and identifying activities and the level of required assistance to support the patient in his own home.

Staff assured that there was a tailored and innovative approach to providing an integrated person centred pathway of care for people with complex needs that involved other service providers.

The service provided reasonable adjustments so people with disabilities could access and use services on an equal basis as others. We were given examples where staff said they changed the layout of a room to accommodate for the patients' visual needs. We were

also told if a patient required a family member to be present during a therapy session the service made reasonable adjustments so that the family member can stay with them overnight.

The service provided an add-on transition service which included a liaison service with existing care arrangements to ensure a smooth transfer to Ascot Rehab and continuity of care, health insurance assistance, transport to and from airports, hospital and hotels, preferential room rates at local hotels for family and friends, transport for family and friends to and from London and a list of entertainment nearby for family and friends such as shopping, restaurants and spas.

Staff worked across all teams to coordinate patients' involvement with families and carers. Staff invited families and carers to join therapy sessions, when appropriate, to address patients' needs. The service said this was important because it helped support the rehabilitation programme and promote patient independence. We were given an example where a patient who was discharged home and then re-admitted needed an update of skills and competency training for the carers. Carers were integrated into the rehabilitation team and staff supported them during discharge. This was coordinated across all therapy modalities and aimed at improving the person's independence as well as supporting carers in identifying when they should support the patient and when to promote independent practices.

The service actively addressed institutionalisation by encouraging patients to maintain relationships with the people that matter to them, inspiring continuation of care and social interaction. We were given examples of patients who were supported in a community setting to follow their interests and take part in activities that were socially and culturally relevant to them. Examples included attending pub quizzes and going to the movies. We were also told that some patients with religious requests were given the opportunity to access and have therapy support while attending religious services.

Access to the right care at the right time

People accessed services and appointments in a way and time that suited them.

The service screened patients prior to their admission. This was done face to face when possible and based on medical notes and telephone contact with the patient and medical team when unable to do the face to face screening. Screening patients prior to admission insured that people admitted to the service were appropriate and met referral criteria such as presenting rehabilitation goals and being able to actively participate in rehabilitation. This process also supported timely access to initial assessments, test results and treatment as the service would identify the patient's medical needs prior to admission. Patients were introduced to their therapy team and consultant within the first 24 hours of admission and given time to settle in. We were told that the average waiting time to access the service once a referral was completed was three days.

The service had a service level agreement with a private hospital which ensured that any test results could be processed with urgency and prioritised. This meant treatment for patients was provided as soon as medically possible.

Staff engaged patients in determining an appropriate time to have their therapy sessions. Staff explained the objectives and targets of the therapy session and liaised with the patient to arrange the session times. Therapy was provided through an in-house team and appointments were kept to time. If a patient did not want to do a therapy session at a particular time the next available slot was offered as alternative options most of the times within the same day.

During inspection the service said there were no current waiting lists. We were not informed of a time where there had been a waiting list for the service, however, if the service was to capacity it would use the pre-admission assessment as a form of prioritising people with more urgent needs.

The service provided inpatient and outpatient rehabilitation alongside inpatient care. Therapy sessions for inpatients were arranged on a patient needs basis. Outpatient services were booked in advance and according to patients and therapists availability. This enabled patients, their family and care support to have access to appointments within a suitable and available time frame. During a patients' rehabilitation programme there were no reported cancellations or delays to treatment unless the patient was unwell or unable to participate in rehabilitation due to medical reasons. We were told if a staff member was ill or unavailable a

member of the team would replace them for the session and maintain the ongoing rehabilitation plan. We were also told treatments were rescheduled as soon as possible to minimise the impact of bed rest and decreased carryover.

Learning from complaints and concerns

People who used the service were involved in regular reviews of how the service responded and managed complaints. The service demonstrated where improvements had been made as a result of learning from reviews and how this was shared across all members of staff.

People who used the service knew how to make a complaint or raise concerns. There was information available on how to escalate a complaint through leaflets, a comments box at the entrance of the service and directly through staff if people felt comfortable to do so. Staff said they would encourage and support people making a complaint.

Staff felt confident to raise issues with the service manager and were asked to be honest and forthcoming when they needed to speak up. The service had a complaints policy which was part of the induction programme for staff members and staff we spoke to knew where it was located and had easy access to it.

The service aimed to acknowledge the receipt of a complaint within two working days of receiving it and respond to all complaints within the next 20 working days. Staff always acknowledged the persons complaint and attempted to manage the complaint when it was being made. If the complaint couldn't be managed at a first level it was escalated to the service manager and then to the executive team, if necessary. Complaints were logged and recorded for future training and theme analysis. The service reported they had always met the target for complaints received.

The service reported one complaint between the reporting period of February 2017 and January 2018. There were no complaints referred to the Parliamentary Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) in the same reporting period.

Staff were aware of complaints and acknowledged their receipt. Staff provided examples of learning from formal and informal complaints such as ensuring that the staff toilet is clearly identified, implementing new guidelines on families bringing in food for patients and ensuring consistency in the way the service communicated with patient families by establishing earlier case conferences. We saw evidence of complaints being handled in an open and transparent way whilst ensuring confidentiality.

Are community health inpatient services well-led?

Good ●

Leadership

We saw there were clear lines of accountability and responsibility. Staff were aware of their responsibilities and who they reported to.

Staff told us leaders were visible and approachable. Staff knew who the leadership team was and their close working relationship.. Staff were complimentary towards leaders and told us they felt comfortable in approaching them and the management team if they have any question or needed their support.

We saw interactions between service leaders and staff. These appeared to be supportive open and honest. Patients we spoke to also said they knew the leadership team and felt they had their attention should it be necessary to talk.

The leadership team had implemented a scheme of delegation which provided resilience for their sickness and absence. We heard from management that staff were given skills and competency training to do this. Staff said they had opportunities to train in leadership programs such as those offered by their professional bodies or through external agencies and where supported by management to do this.

The leadership team understood the challenges to quality and sustainability for the service and were addressing these issues. We saw evidence of this in three most recent senior managers team meetings minutes. Sustainability issues were identified as continuing with a steady flow of referrals, the effective marketing of a new service, maintaining a good workforce, being competitive and advertising the uniqueness of the service such as the

live-in suites and respective step-down procedure. Challenges to quality were the aspiration to achieve service goals within a short time frame and occasional over-provision of services.

The leadership team addressed quality and sustainability issues jointly with staff members. This was done as part of the in-service training for staff, by presenting service achievements in clinical practice at conferences, developing business proposals for sustainability and maintaining an investment in innovative equipment and technology.

Vision and strategy

The service presented a clear vision and set of values that had quality and sustainability as the top priorities. The service's vision was to be the leading centre of excellence in rehabilitation services, providing the highest quality of rehabilitation and care to their patients. This was in line with the service's mission which was to offer high quality, consultant led rehabilitation services to patients enabling them to lead their lives as independently as possible.

Staff were aware, understood and implemented the vision, values and strategy of the service. Leaders also understood the impact of their role on trust culture and their interaction with patients. We were given examples of how engagement with patients and families was linked with the value and visions of the service and these were in line with what the service promoted.

The service developed their vision, values and strategy in collaboration with staff. However, there was a recognition that a review of the current values of the service was needed because the service had progressed since they were created. The service manager said this would be done with the contribution of stakeholder groups for patients and staff and the use of away days and team planning days.

The service had a clear service development plan for the following two years. We saw evidence of this in the Ascot rehabilitation annual plan 2017-2018. The development plan was realistic for achieving their priorities. Leaders told us they used previous experience and benchmarking with other hospitals to support the development of these plans.

The service aligned their strategy with local plans from the wider health and social care economy. For example, there was an aim to develop specialised community rehabilitation services because the provision of local community services had decreased. The service also identified a need to improve pathways of their case management portfolio particularly between discharge from hospital and initiating therapy at the service.

We were told that the service monitored and reviewed the delivery of their strategy in line with local plans. For example, the service was monitoring discharges that required support from community services or had links to social care services. This was done via telephone conversations or feedback from previous patients.

Culture of high quality and sustainable care

We saw the culture within the service was one of pride in their work and a desire to deliver high quality care which reflected the service's values. The service manager told us they were very proud of the staff and said staff always 'pulled together'.

Staff felt supported, respected and valued. We spoke to staff who felt they worked in a place for which they had dedication. Staff said there was a supportive relationship amongst staff from different professional backgrounds and a shared sense of responsibility towards the patient. Staff also said that the service culture was centred on the needs and experience of people who used the services. We heard examples of patients' needs and requests being taken into consideration and part of the development plan for the service.

Leaders and staff understood the importance of being able to raise concerns without fear of retribution. Staff gave examples of openness and transparency when they had to raise issues with senior management.

We saw evidence of appropriate learning as well as actions taken because of concerns raised in the services' risk register. Management of these concerns was done jointly between leadership and staff and addressed the relevant issues.

The service provided mechanisms for development of staff at all levels. These included appraisals, supervision and open discussions with senior management. Training was available and offered to all staff in line with services needs and staff appraisals.

Staff we spoke to felt they could raise concerns about safety and wellbeing with the leadership team. Leaders said they were open and transparent and considered the

personal circumstances of each member of staff when dealing with concerns of safety and wellbeing. We heard an example of a member of staff who had fallen ill and how the service had supported their phased return to work.

In situations of conflict there was a clear escalation process. Staff had access to policies such as the Bullying and harassment policy to support them as well as being able to escalate issues to the service manager if they felt unable to resolve any issues.

Leaders identified that there were limits to career progression due to the small size of the service. However, support was offered to staff who wished to develop within their role. The service also encouraged shadowing and secondments into more senior roles when possible.

Governance

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services were set out, understood and supported the delivery of a good sustainable service.

Leaders were aware of areas of improvement to address service needs such as mandatory training compliance. And IPC! We were told during inspection that there would be a review of the system of accountability for mandatory training compliance. This would involve key stakeholders such as human resources, clinical directors and heads of therapy to ensure mandatory training compliance rates would be within the targets established by the service.

The service had an effective governance structure. Staff were aware of the governance structure and who senior management were and their roles and could easily escalate issues through them.

Staff members were clear about their roles and who they were accountable to. Staff gave us examples of how they participated in auditing incidents and risk management processes both at an individual and organisational level.

We were told reviews of policies and procedures were regularly conducted and ratification was completed by senior management. We saw evidence of this in the minutes of the senior management team meetings. Dissemination was made through the service manager who then highlighted changes to relevant policies through emails and staff communication forums. Clinical leads for each discipline were actively engaged in monitoring changes at a professional level.

The service identified there was room for improvement regarding training request responses as it was slower than usual. The service also identified a need to increase links and working relationships between the site and head offices to become more conjoined with the executive team. The service was also trying to implement a new referral process using more resources from administrative support and international offices.

Management of risk issues and Performance

The service provided evidence of comprehensive systems and performance issues being escalated appropriately. These were reviewed, monitored and given accountability for implementation. The service leaders knew when to escalate issues to the senior executive team.

Staff raised risk and performance issues through the staff worry list. Risk meetings were attended by at least by one element of each professional team. We were told issues were raised to the heads of service and then to the service manager. Risk meetings happened every four to six weeks and addressed incident forms and audits. We were given an example the effectiveness of this system when a lift was not operational. This was raised as a risk and one of the actions identified was staff training for lift evacuation which was provided to key staff members. However, the service has identified the need to improve the feedback loop to staff on incident reporting in a more timely way.

We reviewed the minutes of the last three senior management team meetings. We were assured the service and the leadership team addressed issues and risks in an effective way.

There were robust arrangements to identify, record and manage risks. These were monitored and audited and actions were identified and acted upon appropriately. We saw evidence of this in the services' risk register regarding issues such as the management of escalation data and informatics.

There were sustainable arrangements for service continuity plans when potential risks occurred. We were

assured of effectiveness of these. As an example, there was a plan for seasonal risks such as summer heatwave recommendations as well as snow and access risk assessments.

Service efficiency changes were monitored in line with quality and sustainability through an extensive audit programme. Quality and sustainability was a standing item on service meetings. We saw examples of this in a cleaning audit which identified areas for improvement in the occupational therapy kitchen and their impact on patient safety. One of the solutions was to address these issues with the purchase of new equipment that was more efficient in its functions, easier to clean and more supportive of patients' needs.

Leaders told us performance issues were managed on a case by case basis. These would be addressed through supervision, direct line management and based on performance and timed outcomes linked to the development needs of staff.

Information Management

The service presented a holistic understanding of performance and integrated people's views into information and quality. This information was used to measure improvement. For example, quality and sustainability of the service and patients' needs were addressed in all relevant meetings. Staff had access to information to challenge it if appropriate.

The service had clear performance measures which were reported and monitored. The service used patient centred outcome measures and customer satisfaction questionnaires to measure qualitative information. This gave leadership insight into how patients experienced their rehabilitation and how they felt about their progress. It also helped leaders identify how patient experience could be improved. Alongside the qualitative measures the service had outcome measures which served as benchmarking tools. This quantitative information provided the service with data as to how they were performing and help identify areas where service development and targeted service improvement interventions should take place.

The service ensured information was monitored and managed within an accurate, valid, reliable and timely way through their auditing program. We saw evidence of audit reviews being held regularly at meetings at all staff levels. Additionally, we saw a service audit calendar that specified the planned audits for the year.

The service reviewed Information from the audit programme and used it as a learning opportunity to further manage and monitor development. The service produced a yearly quality report. The report was available on the internet page for all interested stakeholders to read it.

The service manager ensured notifications were effectively managed and submitted to external bodies as required. We saw evidence of good succession planning and appropriate delegation of responsibilities within the organisation should key staff members be absent or unable to fulfil their duties.

We were told the service had working groups that addressed accreditation and delegation. Information provided to accreditation groups was reviewed and double checked by the service manager and cross-referenced with the head office ensuring the quality of the information provided.

External and identifiable data such as patient records and service data management complied with data security standards. There was an effective policy in place to manage this and there had been no reports of data security breaches up to the inspection.

Engagement

Leaders gathered people's views and experiences to shape the service and its culture. The service proactively engaged and involved all staff and ensured all stakeholder voices were heard and acted upon.

Staff and service users regularly engaged in feedback on how to improve the service and accommodate for people's needs. We heard several examples of requests patients had made and how leaders accommodated and incorporated these requests into service development.

The service had positive and collaborative relationships with external partners such as Headway, embassies, local authorities and GP services. Staff and management felt these relationships were stable but could be improved to streamline services. The service had engagement plans to continue to strengthen current relationships and were actively searching for new relationships.

We saw evidence of transparency and openness with all stakeholders. As an example, the service's quality report was published every year and made available through the services' internet page.

Staff engaged with senior management and the executive team through the yearly staff survey. The service manager operated an open-door policy and made themselves available to discuss any topics staff or patients would like to address. The service also promoted staff engagement through email and messages that were disseminated down from the executive team, medical director and service manager to other staff. Computers were always available for staff to access the intranet or email.

Service leaders were available to engage with patients and their families and carers. This gave friends and families the opportunity to talk about their patients care and provide informal feedback regarding service delivery. Feedback from families and patients was positive saying it gave them a chance to be honest about their concerns. Leaders we spoke with said this was "really positive and made you feel your work is not going unnoticed".

Staff said they felt appreciated by the leadership team and that the engagement process was meaningful.

Learning continuous improvement and innovation

There was a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. The service made use of internal and external reviews and learning was shared effectively.

Leaders supported staff to ensure continuous learning, improvement and innovation by providing them with opportunities to escalate personal development needs through appraisals and service development plans. There was a focus on patients' needs during this process as well as a provision of a financial platform to incorporate innovation.

Staff were encouraged to use information delivered by leaders to identify team objectives and areas of innovation. We saw examples of innovation and learning such as the use of Functional electrical stimulation to measure change in swallowing pre and post- treatment using intensive surface electromyography.

The service participated in research projects and had gained recognised accreditation through external agencies such as the Comparative health knowledge systems. This allowed the service to have a benchmark against large providers of healthcare in areas such as health care intelligence and quality improvement.

The leadership team encouraged staff to take time to work together to resolve problems and review individual and team objectives, processes and performance. We saw this had led to improvements in areas such as patient coordinated care as well as strengthening the services' interdisciplinary model of care.

We were told the service had looked to improve patient feedback and increase stakeholder events to improve service innovation. Leaders supported staff to promote continuous improvement through staff awards and creating opportunities for staff training and continuous professional development with internal and external sources.

Outstanding practice and areas for improvement

Outstanding practice

- Use of doppler scanning to address patients risk of developing pressure ulcers in addition to standardised assessments.
- Use of the core values assessment to promote dignity to patients.
- Innovative treatments such as the robot assisted automated treadmill and a self-initiating arm and hand therapy rehabilitation exercise device.
- Use of a transdisciplinary model of care that promoted a truly whole person approach to rehabilitation. We saw continuity of care and a staff working on patient centred goals while helping manage expectations and needs.
- The service had an imbedded culture of care for the patient and supporting families and social networks to work as a whole.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure all relevant mandatory training is reviewed and updated as per service policy.
- Consider ways to improve access to all equipment and promote safe practice in the storage room.
- Address the safety and contamination risk of the clinical waste compound with the landlord. Bins and storage areas should be locked and the storage area accessible only to members of staff who require access to it as stated in the Health Technical Memorandum 07-01: Safe management of healthcare waste.