The Royal Buckinghamshire Hospital

Quality Report

The Royal Buckinghamshire Hospital
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Date of inspection visit: 29 August 2018 and 5 September 2018
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

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.

Summary of findings

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 Royal Buckinghamshire Hospital is operated by The Royal Buckinghamshire Hospital Limited. It has 22 beds and offers inpatient and outpatient rehabilitation for patients who have a spinal cord injury, acquired brain injury, stroke and other neurological conditions.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on the 29 August 2018 along with an announced visit to the service on the 5 September 2018.

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

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

Our rating of this hospital/service went down. We rated it as requires improvement overall.

Our key findings from this inspection were as follows;

- Patients' risk assessments were not always reviewed regularly and not always consistent in identifying a patient's level of risk.
- Evidence from the provider's electronic quality dashboard did not match with the service's accident and incident tracker. The service could not assure themselves all incidents had been investigated where required.
- The service could not evidence comprehensive systems and auditing processes were in place to identify key risks to service provision ensuring mitigating action had been taken.

However we found areas of good practice;

- Each patient'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.
- Patients had access to a range of clinical specialists to support them in their rehabilitation journey and their personal outcome goals
- The new manager was providing strong, recognisable leadership which was valued by staff. They had identified areas for improvement in the working practices and procedures of the hospital since starting at the service and, at the time of the inspection, had already been acting to address these.

We also found areas of outstanding practice:

- We saw an embedded practice of person centred care with staff highly motivated to provide care respectful of patient's privacy and dignity. Positive relationships were created and nurtured to ensure patients fully engaged with their rehabilitation journey.
- Continuous positive feedback was received and viewed which praised staff for their caring nature.
- Friends and friends important in patient's lives were actively encouraged and supported to be part of their rehabilitation journey enabling them to continue being involved in the patient's recovery once discharged from the service.
- The care provided to patients was outstanding, patient's were supported by staff who had an embedded culture of meeting their emotional and physical needs. Patients were empowered and offered with opportunities to share any emotional concerns they had.
- Staff took the time to develop genuine, warm and respectful relationships with patients to ensure they felt fully supported throughout all aspects of their care and therapy.

Summary of findings

- Staff exceeded what was expected of them in their roles to ensure they recognised and took action to ensure patients received highly individualised and compassionate care. Staff went over and above their roles to offer care to patients so they could experience important and significant life events.

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

Amanda Standford

Deputy Chief Inspector of Hospitals (South and London)

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at; Community health inpatient services

Summary of this inspection

Background to The Royal Buckinghamshire Hospital

The Royal Buckinghamshire Hospital first opened in 1862 and had direct links to Florence Nightingale and the Rothchild's family which led to the naming of the two hospital wards, Rothschild and Nightingale.

The hospital has 22 beds and offers inpatient and outpatient rehabilitation for adult patients who have a spinal cord injury, acquired brain injury, stroke and other neurological conditions.

The Royal Buckinghamshire Hospital is registered to provide the following regulated activities, diagnostic and screening procedures and treatment of disease, disorder and injury.

At the time of the inspection, a manager who had been appointed in April 2018 was in the process of becoming registered with the Care Quality Commission.

The service has been inspected twice since originally registering with the CQC in 2014. The most recent inspection took place in April 2016 which found the hospital was meeting all standards of quality and safety it was inspected against however, one recommendation had been made for the provider to review their out of hours admissions procedure. This recommendation was reviewed as part of this inspection. The inspection in April 2016 had been completed by adult social care inspectors as the hospital was previously registered as a nursing home.

Prior to, and during the inspection the hospital was actively completing a change in their registration to become a specialist rehabilitation centre which provides nursing care. This would return their registration an adult social care registered location, following this inspection.

Facilities at the hospital include private patient bedrooms, private apartments with self-catering facilities for patients' families and friends, a purpose-built hydrotherapy pool, three rehabilitation gyms and 20 treatment and therapy rooms. These include woman only therapy rooms, individual consulting and therapy rooms for group therapy and psychotherapy consultations.

The service treats private and NHS patients from across the world working closely with health insurance providers and legal firms.

Our inspection team

The team which inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in neurorehabilitation. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

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 carried out this routine inspection as the service had not been inspected since registering as a hospital in 2017.

How we carried out this inspection

During the inspection, we visited both wards in the hospital, Rothschild and Nightingale. We spoke with 19 staff including; Nurses, healthcare assistants, therapy staff, housekeeping and maintenance staff, human

Summary of this inspection

resources administrator, the provider's quality and compliance manager, the provider's managing director/ Director of Operations, deputy manager, clinical nurse specialist and the manager of the service. We spoke with four patients and one relative.

During our inspection, we reviewed nine sets of patient records, reviewed maintenance and health and safety documentation, audits and other documents created during the provision of the regulated activity. We also observed care and therapy being provided in treatment areas within the hospital and support provided to patients during two mealtimes.

We asked the provider to supply updated training figures and other information relating to the management of the regulated activity post inspection.

There were no special reviews of the service ongoing by the CQC at any time during the 12 months before this inspection, however, a patient fall with harm was in the process of being reviewed by the CQC at the time of the inspection.

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Information about The Royal Buckinghamshire Hospital

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Activity (August 2017 to August 2018)

- In the reporting period August 2017 to August 2018 there were 54 inpatient and outpatient case episodes of care recorded at the Hospital; of these 2.6% were NHS-funded and 97.4% other funded.
- 100% of all NHS-funded patients and 44.3% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 1713 outpatient total attendances in the reporting period; of these 100% were other funded with no NHS-funded patients.

Two regular resident medical officers (RMO) worked on a two week rolling rota. The hospital employed 18 registered nurses, 32 health care assistants, nine physiotherapists, six occupational therapists, seven rehabilitation assistants and one receptionist, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the service's Deputy Manager.

Track record on safety for the last reporting period

- 0 Never events
- Clinical incidents (removed facilities for example)
- 25 no harm
- 21 low harm
- Six moderate harm
- One severe harm
- Two serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- One incident of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- 14 complaints (from December 2017. Previous records archived at the time of inspection).

The hospital also rented out consultant rooms for private consultations, we did not inspect the service provided by these separate individuals.

Services accredited by a national body:

Summary of this inspection

- Independent Neurorehabilitation Providers Alliance (INPA)

Services provided at the hospital by external companies/providers:

- Clinical waste removal
- Interpreting services
- Dietician services
- Speech and language therapist services (however, the service was in the process of employing their own internal therapist in this area)
- Clinical phycology services (however, the service was in the process of employing their own psychologist to support the hospital)
- Neuropsychology
- Music therapy
- Registered mental health nurses
- Sexual Health Specialist advisor
- Music therapy

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as Requires Improvement because:

- The service had identified mandatory training skills for staff and offered this training on a regular basis. The service however, did not have a system in place which allowed staff to accurately identify when they had completed or required update training.
- Staff had not received the minimum standards of safeguarding children training as required by their role.
- Patient's risk assessments were not always reviewed regularly and not always consistent in identifying a patient's level of risk.
- Evidence from the provider's electronic quality dashboard did not match with the service's accident and incident tracker. The service could not assure themselves all incidents had been investigated where required.

Are services effective?

Good

We rated effective as Good because:

- Patients 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.
- The service supported patients to ensure their food and dietary requirements and preferences were met.
- Clinical staff received the training and supervision they required to maintain their professional accreditation.
- Patients had access to a range of clinical specialists to support them in their rehabilitation journey and in their personal outcome goals.
- Patients were supported by staff who understood the requirements and application of the Mental Capacity Act 2005. Where patients could not consent to any aspect of their care or treatment best interest processes were followed and care delivered to maintain a patient's health and wellbeing.

Are services caring?

Outstanding

- Caring, respectful and friendly relationships had developed between highly motivated staff, patients and their family members. Staff showed genuine concern for patient's wellbeing when delivering care and therapy which met went over and above meeting their individual needs.

Summary of this inspection

- Staff displayed genuine empathy and warmth during care and therapy delivery. Staff demonstrated the embedded recognition of the importance of ensuring patient's emotional needs were identified and addressed. The service offered patient's and their family members the opportunity to seek counselling to help them address any emotional concerns they may have.
- We saw an embedded practice of person centred care with staff motivated to provide care respectful of patient's privacy and dignity. Family and friends important in patient's lives were encouraged to be part of the patient's rehabilitation treatment enabling them to continue the patient's recovery once discharged from the service.

Are services responsive?

Good

We rated responsive as Good because:

- Patients received care which was tailored and designed to meet their individual needs and preferences.
- Patients were provided with opportunities to ensure their spiritual and religious needs and beliefs were met.
- The service ensured communication aides were available and practiced by staff to allow patients to share their needs and preferences.
- The service responded positively to patients' complaints and concerns to ensure the quality of the service provided was improved as a result.

Are services well-led?

Requires improvement

We rated well-led as Requires Improvement because:

- Staff could not accurately describe the service's visions and values but recognised the service's objectives to deliver high quality care and support.
- The service could not evidence comprehensive systems and auditing processes were in place to identify key risks to service provision allowing for mitigating action to be taken.

Requires improvement

Community health inpatient services

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

Are community health inpatient services safe?

Requires improvement

Mandatory training

The provider had identified the mandatory training required by staff to ensure the safe delivery of care. However, the provider could not evidence systems in place to monitor staff training compliance were accurate. As a result staff had not always met the provider's target for mandatory training subjects.

Staff received training in core subjects to support patients who had additional vulnerabilities such as those living with dementia for example. Staff told us they received eLearning training and were tested upon completion to ensure they had understood the content.

The service 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: the service manager, head of therapy, nurses, rehabilitation and healthcare assistants.

Mandatory training for medical staff, consultants and registered medical officers, included, countering bribery and corruption, epilepsy, equality and diversity, handling violence, aggression and complaints, information governance, record keeping and Caldicott, manual handling, prevention radicalisation, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations and the mental health act, for example. This training was completed and in date until January 2019.

Mandatory training for all other staff, other than medical staff, included, basic life support, dementia, equality and diversity, fire awareness, foods and nutrition, infection prevention and control, mental capacity act and deprivation of liberty safeguardings, moving and handling and fire aid for example.

The service identified mandatory training required to be completed by all staff with an expected compliance rate of 90%. We saw completion rates of most training subjects did not meet this target figure which was due to issues with the services electronic training schedule.

The service had moved to using a new electronic training schedule approximately five months prior to the inspection. This system generated compliance rates and provided reports which identified when staff members required training or refresher training. The service had identified this system was not working as planned however, were unaware the extent of which it was providing inaccurate information. The service had not taken action to ensure staff training records were reviewed and maintained whilst this issue was addressed to ensure all staff remained appropriately trained for their role.

Figures available at the time of the inspection identified staff had achieved an overall compliance rate for all mandatory training of 67% with nurses only achieving a 37% completion against medicines training. However, individual records reviewed evidenced a higher level of completion. Immediately following the inspection, the provider offered evidence showing a 77% compliance with mandatory staff training areas. This discrepancy however, had not been fully identified or managed prior to this inspection.

The service had organised to work with the software developer post inspection to ensure these figures were updated appropriately. However, at the time of the inspection, this system in place negatively impacted on the overall compliance figures provided. No alternative system had been put in place to identify and ensure staff received the training they required at the appropriate time intervals.

Safeguarding

Staff received safeguarding adults training and evidenced they understood the content and how to recognise and refer a safeguarding concern, however, no staff had completed safeguarding children training as required by their role.

Training figures identified 91.36% of all staff had received training in safeguarding adults level two. To further support staff the service had a comprehensive adult safeguarding policy which was known and accessible as electronic and hard copies on the premises. There was a clear pathway to escalate safeguarding issues internally to the service's organisational lead and external bodies including the local authority safeguarding teams.

The service had posters displayed in staff areas which identified a three-step guide to managing safeguarding concerns. This identified immediate action required by staff to keep patients safe and provided advice on how to contact the local authorities safeguarding teams, both within and out of office hours.

No staff had completed safeguarding children training however, as the service did not believe this was required due to only providing support to adults. The intercollegiate document (Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document Third edition: March 2014) states;

'To protect children and young people from harm, all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely.'

This was brought to the manager's attention who arranged safeguarding children training to take place the month following the inspection. This would ensure all staff received the training they were required to hold as part of their role.

Despite not receiving child safeguarding training, staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse children and adults could experience. Staff were knowledgeable about their responsibilities when reporting safeguarding incidents and felt confident to report any concerns.

Robust recruitment procedures ensured patient were assisted by staff with appropriate experience and who were of suitable character. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence pre-employment checks had been made which included obtaining written references with regards to applicant's previous work experiences and personal character. Recruitment checks also included a Disclosure and Barring Service (DBS) check and these were repeated annually. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with patient who use care services.

Cleanliness, infection control and hygiene

The majority of staff had received training on infection prevention and control, with a 85% completion rate. Most evidence indicated safe infection control practices were followed.

Environment cleaning was provided by an onsite housekeeping team and completed daily with cleaning schedules completed and signed as up-to-date. Staff said they were happy with the level of service they received. Outside the working hours of the onsite housekeeping team, staff were responsible for cleaning equipment used such as chairs and hoists, we saw this was completed using disinfectant wipes.

The service provided appropriate and adequate quantities of personal protective equipment for example, gloves and aprons in a range of sizes. These were available across the hospital 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 throughout the hospital which was used by staff.

The service offered a deep clean to each room prior to admission, following discharge and on a 15-day cycle. This was part of the service's deep cleaning checklist. Curtains were taken down, washed and replaced, upholstery steam cleaned and mattresses sent for disinfection with an external service. This ensured ongoing infection risks to patients were minimised.

We found patient rooms, treatment, therapy areas and the hospitals hydrotherapy pool were visibly clean and free from dust and debris. 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. We identified however, one incident where cleaning practices were not completed thoroughly.

On the first day of inspection we identified a shower trolley on the second floor had dirt under the mattress. This was brought to staff attention, however, on the second day of the inspection dirt and moisture remained under the mattress indicating it had not been removed to be cleaned thoroughly. There had been no 'I am clean' sticker indicating it had been cleaned by housekeeping staff during this inspection. The manager was advised and acted immediately following the inspection.

We observed safe hand hygiene practices were followed to minimise the risk of cross infection between patients. Hand sanitiser gel units were located throughout the hospital and staff were seen to consistently use them. Staff were observed to be 'bare below the elbow' in accordance with the national institute for health and care excellence (NICE) guidance.

The service complied with health building notes (HBN) regulations 00-09: Infection control in the built environment as a sluice was located on each patient occupied floor of the hospital.

The service managed laundry in an effective way to minimise infection. Clothes and linen which did not present an immediate infection risk was washed using the in-house laundry room. A patient's laundry was collected, washed and pressed in their own, labelled bag to ensure any risk of cross contamination was minimised and ensured laundry was returned to the right patient.

Infection prevention and control (IPC) practices were audited monthly. We reviewed the results of 12 audits completed between January 2018 to August 2018. The lowest compliance rate for the Rothschild Ward was 83% in February 2018 however had improved to 95% in March and remained consistently at above 90% whilst the ward was opened. The Nightingale ward had identified an 83% compliance rate with IPC measures in March 2018 however had increased to an average rate of 94.2% compliance for the period April to August 2018.

The service had an effective system to manage waste disposal with correct disposal of yellow bags, red bags, orange and black bags with gloves and aprons. This was in line with the Health Technical Memorandum 07-01: Safe management of healthcare waste. Guidance was provided to staff on how to manage waste effectively and staff described safe waste disposal procedures. Staff had easy access to a biohazard spill kit to immediately manage any potentially hazardous material.

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).

There was a service level agreement with a waste disposal company as per the Hazardous Waste Regulations 2005 with disposal certificates indicating weekly collection. Staff ensured waste was stored, labelled and handled correctly before disposing in secured external waste bins.

Environment and equipment

Appropriate equipment was available to support patient's in their rehabilitation journey with an environment designed to support patients to move around the hospital as independently as possible. Staff had access to adequate, well maintained equipment to perform their jobs.

Resuscitation equipment was observed to be in working order and checked regularly for fitness of use. Staff completed weekly checks which were documented to evidence their completion.

The service had 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 saw therapy equipment across the service were all serviced, tested and labelled according to electrical safety and provider guidelines. Equipment storage was well organised, well-stocked and clean with dirty and broken equipment segregated appropriately.

The estates manager ensured all facilities such as the hydrotherapy pool and patient lifts were serviced annually to remain fit for purpose. Records showed annual testing for all moving and handling equipment including hoists, slings and bimonthly lift maintenance had been completed.

The maintenance and housekeeping manager and a member of the therapy team were responsible for organising pool maintenance with weekly water specimen samples taken and submitted to an external agency for testing. Procedures ensured the safe management of the facility should a concern be identified as a result of this testing.

In April, for example, a water sample had tested positive for legionella disease, follow this result the pool was immediately closed and a deep clean completed by staff. Retesting was completed following this work enabling the pool to be reopened to patients. Evidence showed the service used an external contractor to complete annual water tank servicing to keep services safe.

Annual gas safety and emergency lighting certificates were in place evidencing the premises remained safe for patient use.

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.

Staff felt they could escalate issues to the estates manager and said concerns were addressed promptly. The estates manager and staff reviewed the maintenance book for each department and each ward daily. These were used for the reporting of any defects or maintenance requirements. Staff told us and records showed timely rectification of issues when raised.

Patients were kept safe by design and maintenance of the premises. Access to the hospital was granted via a main reception area which was keypad controlled. The hospital's reception was staffed between 8am and 5pm every day and afforded people access once they had signed in identifying who they were visiting. After 5pm access could only be granted by staff working on the wards or the security staff who were employed between 8pm and 8am to keep the premises and patients safe. A patient's family member told us they both felt safe owing to the measures in place by the hospital. They told us, "I've always been impressed with that (security) and they're (staff are) very helpful".

The service had fire extinguishers which had up-to-date servicing. Staff received regular training in fire safety policies and evacuation procedures. Emergency evacuation chairs were available for emergency situations where the lifts could not be operated in the case of an emergency. A fire alarm test was completed weekly and a check round for automatic fire door closures and emergency lighting checks.

Assessing and responding to patient risk

The service used a range of risk assessments, screening tools and record charts to identify, record and document mitigating actions required to keep patients safe. The service could not evidence however, risk assessments were reviewed and followed by staff to keep patients safe. Effective procedures were in place to manage a patient in an emergency which were followed when required.

The service was in the process of creating patient risk management plans which would meet national guidance and policies, however, those in place at the time of the inspection were not always reviewed in line with the provider's own guidance. Only one risk assessment viewed was reviewed regularly to identify if the identified needs of the patient had changed.

Staff completed a falls risk assessment for patients on admission for example, however, risk assessments did not evidence regular reassessment or when a change had been identified in the patient's mobility which would be expected during rehabilitation.

For example, when a patient had moved to the hospital a falls risk assessment had been completed. The patient's risk assessment stated, 'Assess on admission and as clinical status changes (minimum requirement reassess once every seven days)'. This patient's risk assessment had been completed on 6 August 2018 but had not been reviewed by the time of the inspection, in accordance with the service's own guidance. We did however, observe staff providing safe care during the patient's physiotherapy session which met their needs for rehabilitation.

One care plan also provided conflicting information regarding a patient's level of risk in relation to their risk of developing pressure ulcers.

The service used a nationally recognised pressure ulcer risk record which, when completed, identified if a patient was at risk of suffering a compromise in their skin integrity. For one patient this risk assessment had identified the patient at very high risk of suffering a pressure ulcer. The service however, in addition, had completed their own pressure ulcer risk assessment which scored differently and placed the patient at low risk. This meant the patient had no care plan in place to manage their needs. Whilst the patient had not suffered a pressure ulcer there was a risk it would not be managed appropriately and therefore could lead to the patient developing a pressure ulcer.

The services clinical nurse specialist said it had been recognised improvement was required with the completion of care plans and risk assessments. In response, the service had recently allocated each patient a named nurse. The patient's named nurse would be responsible for updating care plans and risk assessments, at a minimum monthly and also when a change in a patient's condition had been identified. The service was reviewing all care documentation at the time of the inspection and had introduced new patient documentation which would be for all new patients to the service. We reviewed this documentation and found it to be comprehensive however, it was not possible to assess the impact this would have.

The service had escalation procedures in place for deteriorating patients which 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.

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 which would indicate a deterioration in their health. We saw this information was used effectively. One patient's NEWS observations indicated a potential decline in their health and wellbeing which resulted in the patient receiving more regular monitoring. When identified as necessary, the patient was transferred to hospital for treatment and returned to the service following this acute episode. Despite their NEWS scores returning to a score indicating low risk to their health, the patient's frequent observations were continued to allow for the immediate response to any potentially rapid decline.

Nurse and medical staffing

The service identified staffing levels and skill mix on a patient needs basis. There was a core team of staff who worked permanently for the service, this consisted of two regular resident medical officers (RMO), 18 registered nurses, 32 health care assistants, nine physiotherapists, six occupational therapists, seven rehabilitation assistants and one receptionist, as well as having its own bank staff.

When patients care needs were identified as requiring more input or more clinical support the service could address these using the service level agreement with other providers to access nurses and healthcare assistants. If the therapy team required more staff to support patient needs they would use of bank or agency staff.

Before the inspection anonymous concerns had been raised with the Care Quality Commission (CQC) regarding the staffing levels provided at the service. As a result, we reviewed three months of staff rotas (June to August 2018), planned and actual to establish if there was cause for concern.

The provider had identified the provision of nurses and healthcare assistants (HCA) required to meet patient

needs. This was identified as one HCA for every three patients (not including patients who required one to one care) and one nurse of every five patients during the day. Overnight one HCA to every five patients and one nurse to every seven patients overnight was deemed as appropriate.

Of the 92 shifts observed, 20 identified a HCA or nurse had not attended work. On these days support was provided by having an over establishment of nurse cover or by utilising the management team of clinical nurse specialist, deputy manager and the manager who were all registered nurses.

The service produced a four-week rota two weeks in advance of its commencement date and had plans to extend this to a six week rota for staffs benefit. This work was ongoing at the time of the inspection.

Rotas confirmed suitable numbers of staff were rostered to work, however, last-minute sickness had forced staff to cancel their shifts. The service used two agencies to provide HCA staff however, in the event of last-minute sickness it was not always possible to secure additional staff. On these occasions managerial staff offered support by attending multidisciplinary meetings and conducting one to one care for patients. This meant more staff were available to work the wards and meet patient needs. The service also had a nurse and two HCAs on a zero-hour contract who could be used to support staff where required.

Service management acknowledged last-minute staff sickness was the service's biggest risk and were taken positive action to minimise any potential impact. This action included sourcing a third staffing agency to provide staffing resilience and reviewing the service's policy regarding staff sickness. This work was to include the completion of back to work interviews to identify the reason for repeated or on the day reported sickness, reviewing the services current allowance of paid sick days and taken action where sick leave was potentially used as a means to seek time away from work.

During the inspection we heard a member of staff call in sick to work and we saw staff immediately commenced seeking another member of staff to fill their position.

Staff provided mixed views when we asked them whether there were sufficient staff deployed to meet patient needs. Therapy staff spoke more positively saying staffing levels were good and felt they were well staffed within physiotherapy and occupational therapy. They told us in relation to patient's care needs cover would be found with management if required which ensured continuity of service for patients. They stated however care staff were, "Very, very busy" and they felt this had not been acknowledged by management. Care staff told us they felt busy and under pressure in the mornings in particular to support patients to get ready for their therapy sessions but all care was being provided as per patient care plan.

A patient and relative told us they felt there was plenty of staff available to support patients but on occasions they would sometimes have to wait up to five minutes for support. Upon using their call bell however, "The call button is always answered, no questions and they're (staff) very good, very, very good". Another patient told us there was a variable response to the speed of answering call bells depending on what other activity was happening in the hospital at the time.

The last call bell audit had been completed in December 2017. This audit did not identify any serious concerns in relation to staff response times, which could indicate insufficient staff numbers deployed. The audit identified for the three-month period between 05 August 2017 to 19 December 2017, 0.8% of the calls (19 out of 2245 calls) had taken staff between four to nine minutes to respond. Five complaints had been received because of the response to call bell times and it had been identified reasons why responses were not within four minutes. These included, staff dealing with an emergency, being unable to immediately find same sex staff to support patient preferences and nurses prioritising those at most need.

At the time of the inspection the call bell audit had not yet been completed so we were unable to review if call bells were being responded to appropriately indicating if staffing levels were a genuine concern. During the inspection however, call bells, when heard, were responded to by staff within a minute of being used by patients.

A resident medical officer (RMO) was available from 9am to 5pm each day and were on call outside of these hours. The RMO was able to attend the service to support out of hours admissions, queries or concerns with patients and consultants visits for example.

Requires improvement

Community health inpatient services

The service had access to a range of external therapy services to support a patient's rehabilitation. When required the service could source a range of therapists including speech and language therapists, dietitian and clinical psychology services. Professionals from some of these specialisms were being sought to be employed by the hospital to expand the level of service provided by the hospital. The service also had access to interpreters when their own staff were unable to offer translation services.

Arrangements for the use of agency staff kept patients safe. The service used the same agency staff wherever possible to ensure consistency with staff knowledge of the hospital's policies and procedures. When deployed agency staff shadowed existing members of staff to become familiar with the service and patient needs. The nurse working with the agency member of staff was responsible for providing an informal induction to the service. The member of agency staff would work with a permanent member of staff throughout the duration of their shift. The service ensured agency staff deployed to the hospital had a full employment history, satisfactory references, had been checked against safeguarding of vulnerable adults children information and had completed training in areas such as moving and handling, first aid, food hygiene, infection control, fire safety and challenging behaviour for example so were appropriate to provide care.

The handovers and shift changes ensured patients were safe. Handovers and shift changes were completed twice a day with an allocated handover time. The handovers involved: nurses, HCAs, a member of the management team and a representative from the therapy team. Staff spoke positively of the information provided during the handover process and how this assisted them in seeking support from the managerial team when required.

We observed a handover where staff discussed each patient in turn, reviewing their physical and therapy needs, medical appointments and any new risks such as toileting needs. This ensured the service safely implement changes to patient care and maintained safe standards of handover care.

Records

'Patient held records' were kept with the patient as they moved between their care and therapy sessions. These evidenced good multidisciplinary team working and information sharing as therapists and nursing staff contributed to completing one patient care record.

Medical notes were organised and contained all relevant patient information. Patients medical notes were safely stored in a locked cabinet in the nurses' station.

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

We saw evidence of audits being completed to ensure care records complied with services standards. From the period January 2018 to August 2018 there had been 10 audits completed of patient documentation. Outcomes of these audits identified areas in which to improve. One of these areas identified the theme of risk assessments and care plans not being updated in line with the services guidance.

To address the shortfalls in the completion of documentation the service had seconded one of the nurses into a supernumerary position. This allowed the clinical nurse specialist and the deputy manager to have more capacity to oversee auditing and re-auditing processes to ensure outstanding issues were rectified.

Issues such as patient forms not being signed or property lists not being completed were rectified and these themes were not seen to be repeated in following audits.

We were told if a patient became medically unwell they would be transferred to an acute hospital. It was the responsibility of the resident medical officer and nurse to complete all handovers and communicate with the hospital regarding the patient's medical condition, medications and background history. The service provided evidence of when such transfers of care were completed and indicated they would establish regular communication with the hospital once the patient was admitted. Staff also told us they visited patients whilst in acute hospitals to offer reassurance and support in providing guidance nursing staff in the acute setting on how to meet their patient's specialist needs.

Patient records viewed contained evidence of specific, measurable, achievable, realistic and timely objectives and long-term goals required for a rehabilitation environment. Records evidenced Goal Attainment Scaling (GAS) against patients identified long-term goals. These were set for patients who were admitted to the hospital for longer than two weeks. GAS is a mathematical method of scoring the extent to which patient's individual goals are achieved in the course of intervention. In GAS tasks are individually identified to suit the patient and levels are individually set around their current and expected level of performance. These were reviewed fortnightly or when required according to a patient's performance. For example, a patient who suffered a recent health decline had a case conference diarised where all health and care professionals, patient and family members were invited to review whether the goals set for them were appropriate.

There was evidence in the patients' records of regular multidisciplinary team (MDT) working. Patient's physical wellbeing and their rehabilitation progression were discussed in weekly clinical meetings with key professionals. The medical director, resident medical officer, manager, deputy manager and heads of nursing and therapy departments all attended these meetings. Meeting minutes were to ensure an accurate record of discussion and agreed actions were documented appropriately.

The patient's GP received full information regarding patient's rehabilitation aims, objectives and progress upon a patient's discharge. Discharge paperwork commenced when a patient was admitted to the hospital which contained regular updates of a patient's progress. Upon the day of a patient's discharge, any changes in relation to the care a patient needed to receive was communicated to the relevant parties. This included when the patient was moved between services or returned home. This information included details of changes in medication for example, were communicated with the patient's GP and any relevant party. The patient's GP or relevant party would then receive a full report of a patient's full programme towards their aims within five working days. This process allowed for any immediate change required in a patient's care to be instantly known to their GP and any other healthcare professionals involved in the patient's care but the longer term aims of care and progress of this to be communicated allowing for this rehabilitation to continue.

Medicines

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

The service had an agreement with a pharmacy company for a pharmacist to supply medicines, review medicine administration record (MAR) charts and support the resident medical officer regarding prescriptions.

The pharmacist completed 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 medicines were missed thus ensuring safe prescribing and administration of drugs. During these weekly audits where areas for improvement had been identified, such as the correct labelling or storage of medicines for example, prompt action was taken to rectify and signed off by the deputy manager. We saw evidence patients received appropriate therapeutic drug and physical health monitoring in line with national guidance. Nurses were informed of medicine changes at handovers or direct liaison with the pharmacist or resident medical officer. All changes were recorded and dated accurately on the patient's notes.

We were informed of the criteria for a patient to self-medicate: if a patient was alert, conscious and deemed to have mental capacity they were supported to self-medicate. All medicines were explained appropriately to these patients, with information provided on how to manage their medicines safely. We saw self-medication risk assessments in place for patients with the ability to self-medicate. Staff emphasised the important of patients taking ownership of their medicines as part of their rehabilitation process. If patients did not present mental capacity staff said they would liaise with the family in line with the Mental Capacity Act 2005 and all relevant decisions would be documented.

Nursing staff managed the medicines trolley appropriately. We saw MARs were completed accurately and the medication trolley was locked and securely stored in the nurses' station.

Patients who were identified as being able to administer their own medicines had these stored in a patient accessible storage cupboard in their bedroom.

The service ensured patients received their medicines as intended with the use of the MAR and patient records. We saw evidence this was appropriately recorded for all patients.

Safety alerts regarding medicines were highlighted as needed and brought to the nurses attention by the provider. These medicines alerts were placed in nurses stations and signed by staff to say action had been taken to ensure any potential risk from use of medicines had been acknowledged.

The service informed a patient's GP's of any changes to medicines and told them if any re-prescribing was necessary upon discharge.

Oversees patients were discharged with medicines appropriate to manage their health and wellbeing whilst remaining available and suitable for dispensing in their home country. For example, some opioid based medicines are illegal in some parts of the world. If a patient required medicines which were not available in their home country a suitable alternative would be sought prior to discharge. The patients would receive this alternative medicine to ensure there was no negative response and was safe for the patient to receive once home.

During the inspection we checked the refrigerators used to store medicines. They were monitored daily to ensure temperatures were within the safe range.

During a recent heatwave it had been identified patients' rooms were getting too hot for the safe storage of medicine. As a result, all patients' medicines were moved from their rooms to the drugs trolleys in the air-conditioned medical rooms. This meant medicines were always stored in line with manufacturer's guidelines.

Incidents

We saw staff understood their responsibilities to raise concerns regarding safety incidents and near misses. The deputy manager and the services compliance and governance manager, where required, were responsible for investigating incidents and sharing learning from lessons across the service. For example, we saw concerns had been raised by staff regarding a visitor to the service asking to speak to specific staff members. It was identified the visitor had no genuine reason to visit the service however, staff images were available in the hospital's reception area. To minimise the risk of similar situations occurring staff photos had been removed from the public accessible reception area and were in the process of being moved within the hospital.

We were given an example of an incident were there was an unexpected early discharge from the service and the learning which came from the incident. The service identified through investigation where the service required to take proactive action to ensure patients with complex needs were kept safe in the event of early discharge. This had led to the service offering training and shadowing opportunities to agency staff and personal assistants who would be responsible for supporting the patients once discharged from the service. This would ensure patients had the care they required as soon as they were discharged from the service.

Managerial staff we spoke to understood the term duty of candour and its meaning in practice and could give an example of when it had been applied. The duty of candour is a regulatory duty which 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 provided reasonable support to that person.

Staff were confident to raise incidents about patient safety if required. A 'Talk to us' poster was displayed in staff areas which provided staff with guidance on when and how staff could raise concerns. This documented advice on who to speak with within the hospital and within the overall service provider to raise concerns about staff, patients or visitors' safety or wellbeing. A 'concern/ whistleblowing' telephone number was also provided to allow staff to raise a concern if they did not feel they were being heard. Staff told us they would express any concerns by speaking to the manager or ward managers if required.

Safety Thermometer (or equivalent)

The service was informed about patient safety by monitoring a number of key areas using their electronic quality dashboard. This provided monthly information on safety indicators such as the occurrence of accidents, incidents, adverse clinical events, infections and pressure

ulcers for example. The results of the dashboard information were discussed at the three monthly clinical governance meetings, to identify whether there are any trends of concern.

The service had other safety performance assessments such as whether a patient could use a call bell. If the patient was unable to use a call bell this was identified as an issue for the multidisciplinary team to address. We saw an example of a patient who was not able to use the call bell but following assessment was found to be able to use a call bell which was positioned on their pillow to call staff attention. This was in place throughout the inspection enabling the patient to seek assistance when required.

Are community health inpatient services effective?

(for example, treatment is effective)

Good

Evidence-based care and treatment

Staff delivered care in line with best practise and the national institute for clinical excellence (NICE) guidelines.

We were told how the use of the NHS England's '10 Principles of Good Rehabilitation Services' was key in developing the service. These were listed on a large whiteboard outside the therapy treatment area to remind staff of their goals with patient care and provide patients with a guide on what to expect from their treatment.

All therapy teams could demonstrate how they used clinical guidelines and evidence based practice to develop their interventions. For example, scientific exercise guidelines for adults with spinal cord injury were produced which offered guidance to indicate the minimum threshold for achieving improved cardiorespiratory fitness and cardiometabolic health. The service ensured fitness was an integral part of patient's therapy plans and they were encoruged to attend additional fitness group activities. Patients were also provided with a bespoke exercise plan to allow them to carry on their rehabilitation once discharged.

Some therapy staff in the service had been trained in serial casting and the use of this to manage contractures. This is when a there has been the shortening and hardening of a patient's muscles, tendons or other tissue which can lead to deformity and rigidity of joints. Patients assessed as appropriate for treatment were put through a serial casting programme. Serial casting involves placing the contractured limb in semi-rigid, well padded cast and using this process to stretch a patient's muscle improving mobility. We saw evidence this had increased a patient's range of motion from being almost continually contractured at a near 45 degree angle to a nearly straight body positioning which offered relief and improved range of motion.

The service had processes and training in place to ensure no discrimination was made when providing care and treatment decisions. This was upheld by personalised care plans which were patient focussed and developed in line with relevant good practice and clinical guidance. This was not always repeated in line with patient risk assessments for example however. Patients with differing abilities and risks did not always have risk assessments which were personalised to meet their individual needs. This was to be addressed with the implementation of new care planning documentation due to occur with the next patient admission however, was not in place at the time of the inspection.

The service was working to integrate 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. This meant for example all aspects of a patient's care was seen as an opportunity to develop their abilities and provide rehabilitation support.

Staff discussed when therapy teams had been involved in care delivery in a way which was not task focused but structured and seen as part of the patient's rehabilitation pathway. This involvement was reinforced with staff and patient interactions observed. During therapy we saw patients were involved as a team member rather than a task based activity. Patients were actively encouraged to see each staff interaction as a potential for exercising their rehabilitation aims to reach their overall objectives.

Staff showed awareness of when patients 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.

The service was a part of accreditation scheme for the Independent Neurorehabilitation Providers Alliance (INPA). The INPA is a network of independent providers working in neurorehabilitation across the UK who meet to discuss current issues effecting the sector and how group members can work together to ensure the best possible care and support is provided to all patients.

The service was due to have their annual inspection immediately following the inspection which would assess their suitability to remain part of this accreditation scheme. Membership of INPA allowed the service to develop their practice in line with new best practice guidance.

Nutrition and hydration

Patients' nutrition and hydration needs were being identified, met and monitored. Where indicated a patient had a nutrition eating and drinking care plan in place identifying what support they needed to stay well.

We saw the service completed their own nutritional screening tool based on the Malnutrition Universal Screening Tools. These were fully and updated when required. The screening tool was used to identify adults who were malnourished, at risk of malnutrition or being obese and included management guidelines which could be used to develop a care plan. We saw care plans, where required, were clear in identifying the hydrational input patients required and included information about what patients wanted to have for breakfast, lunch and dinner, snacks, favourite and disliked foods. The care plans also included information, including images, regarding the body positioning patients were required to take to enable the correct meal time support to be given.

Patients had access to a dietician and speech and language therapist to support 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 had employed a new head chef who was working with patients to deliver meals which met their individual needs and preferences. The kitchen contained information which clearly identified patients' dietary requirements such as modified consistency diets, diabetic meals, allergies or a patient's cultural food requirements. These needs were primarily identified by the multidisciplinary staff team and then communicated to the head chef team through handovers to guarantee patients had their needs attended to in the most appropriate way.

The menu had a variety of options with several dietary choices sensitive, cultural, religious and personal requirements and preferences. A patient and relative we spoke with during the inspection praised the meals provided and the work which had been undertaken to remove the patients feeding tube so they could eat again. Both patient and relative said it was, "unbelievable", the amount of progress the service had made in supporting the patient's journey to no longer rely on a feeding tube. We saw staff offering drinks to patients, their families and other visitors throughout the inspection.

Pain relief

During the inspection staff within care and therapy asked patients whether they were experiencing pain or discomfort. Patient records documented what activities patients had completed during their therapy sessions and if they had experienced any pain as a result. This enabled nursing staff to be aware and offer pain relieving medicines if required.

For patients who were unable to verbally communicate their levels of pain staff either due to the mechanics of their injury or English not being their first language, the service had created care plans to help meet the patient's needs. This included identifying and documenting physical signals to help staff identify if a patient was experiencing pain (increase in levels of agitation for example) and where this pain may be concentrated. This included non-verbal cues such as a patient rubbing their head which would indicate they were suffering from a headache. Staff understood how to recognise and respond to these cues.

Patients able to communicate were verbally asked for their level and location of pain. The service did not use any pain identification charts however, guidance was provided in patient's MARS for nurses on when the use of additional medicine would be appropriate. These were referred to as 'when required' medicines and could include medicines to manage pain which are not frequently required. We saw appropriate information was provided regarding the appropriate use of this additional medicine.

Requires improvement

Community health inpatient services

Patient outcomes

Therapy staff measured patient outcomes using a variety of tools to assess the impact of treatment interventions. Patients were supported, wherever possible, to return to, as much as possible their previous level of independence through joint goal setting. The patients spoke positively of the support they were given by the service. One patient told us, "This place is fantastic, I have been to many placements but this is, by far, the best one for care and rehabilitation".

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 patients receiving care within the service.

Senior staff said six months prior to the inspection patient outcome measures were not being used to evaluate the service's overall patient outcomes. Whilst individual patient outcomes were being assessed before, during and after treatment and therapy, this information was not being routinely collected and monitored to identify how the overall service was operating in comparison with other similar services.

As a result, the service was (now) showing patients' needs were being met using qualitative and quantitative information. The service was used Goal Attainment Scaling (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 used an 'Outcome (wellbeing) Star to assess a patient's rehabilitation journey hand reviewed regularly to ensure patient's identified outcomes were being met. We saw in patients' notes and multidisciplinary team meetings each patient's individual goals were being appropriately identified and achieved. We also saw staff were providing the appropriate rehabilitation and care, to enable patients to achieve their goals within agreed timeframes.

The service monitored patient outcome measures in line with the UK specialist Rehabilitation Outcomes Collaborative (UKROC) but were, at the time of the inspection, not submitting these to the company to monitor the services effectiveness against other similar hospitals. This helped support work identifying if the service was over or under gaoling patients and setting realistic patient outcomes.

The service used information collected from outcome measures and FIM/FAM information to improve therapy provided to patients. We were provided examples of where this had occurred. For example, the use of a Mollii suit. This is an assistive device which patients with muscle stiffness (spasticity) or other forms of motor disability can use in their home environment. It can help reduce stiffness and improve range of motion and functional ability. A patient was encouraged to use the suit and the service introduced a number of outcome measures to assess its effectiveness. Due to the positive effect on the patient's FIM/FAM score this suit had subsequently been used with ten other patients with eight of those showing improvement on their outcome measures.

Patients were supported with a multidisciplinary discharge report in line with their desired goals and outcomes. This included advice for the patient and family members regarding the use of equipment and explaining how the patient would need support and 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 patient's personal assistants who would be continuing the patient's care when discharged from the service. This communication was sent through the multidisciplinary discharge report explaining intervention and outcomes the patient had achieved and was aiming to achieve.

Competent staff

The service offered regular training to all staff teams, we saw this was planned and documented when attended. The service's online training monitoring and compliance tool did not support them in providing easily accessible and reliable information regarding staff training compliance.

The service was working with the software developer immediately following the inspection to identify where there had been cross over in data however, this issue had

not been identified or actioned prior to the inspection. Despite work completed post inspection the service was unable to present true and accurate training figures. From the figures provided, however,

The service was developing their in-house training skills to ensure staff had the training they required to perform their role. The service had their own e-learning company to deliver staff training which including testing phases to check individual staff member's level of understanding, of the subject delivered. The service also offered face to face training and had developed their staff to become 'train the trainers'. This meant they would review training being delivered by accredited staff to ensure they remained appropriate to teach.

Nursing staff received training and clinical supervision to enable them to complete their role. Nurses and clinical staff had received additional training in key training subjects of diabetes awareness, tissue viability, tracheostomy, vents, venflon and venepuncture. These subjects were taught by the service's clinical nurse specialist. Staff spoke positively of the training and professional development offered to them by the service which included financial support to participate in further education.

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 six-month probation period. A new staff member said they had not worked within neuro-therapy before but had done, "Lots of shadowing, training", and had received, "A good induction" whilst working at the service.

During the inspection the service acknowledged a more formal process for new staff would be beneficial. The service created a new orientation and induction training booklet for new staff by the final day of the inspection. This induction training booklet was to become mandatory for all new agency staff. This included testing agency staffs knowledge on health and safety, fire safety, infection control, Mental Capacity Act and Deprivation of Liberty safeguards for example. The agency member of staff would be required to sign off when they had completed the relevant parts by their training facilitator.

The service identified additional staff learning needs through regular supervision and annual appraisals. Staff received monthly supervision and nursing staff received alternate monthly clinical and leadership supervision. We reviewed supervision sheets which showed a structured process with issues raised, discussed and documented. Where required action plans were discussed these were signed by the supervisor and supervisees to evidence an accurate capturing of discussions.

We were told poor or variable staff performance would be identified and managed through the service's manager. Staff would be supported to improve performance through open discussions as well as identifying development needs in their appraisal programme. If required new staff would have their probationary period extended whilst they worked with their supervisor on addressing any performance issues identified.

Nursing and therapy staff were aware of sepsis, the infection control and barriers required to manage patient care needs, including an awareness, and practicing of, handwashing policies/procedures. A member of nursing staff we spoke evidenced a good understanding of the signs and symptoms a patient with sepsis could display and the appropriate steps to take to manage a health deterioration accordingly. This included requesting doctor advice, taking bloods for cultures, managing antibiotics and completing regular observations.

Multidisciplinary working

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 assessing, planning and delivering care and treatment. We saw evidence of this in the patients' care plans and daily notes.

We reviewed the notes from a weekly clinical meeting which was a multidisciplinary team meeting inclusive from lead staff from all aspects of care and therapy. During these meetings, each patient was discussed and any actions required to support their rehabilitation programme. We saw arrangements for working with other health and social care professionals to help plan and deliver care, treatment and support patients in a holistic and joined up way, this included the clinical psychologist, dieticians and speech and language therapists.

Case conferences were held when the views of other professionals such as speech and language therapists, clinical psychologists, as well as family members were sought when discussing a patient's health and wellbeing.

We saw these were well attended and provided a holistic overview of the patient's care, ensuring all relevant parties were involved in discussion on the best action to take to meet the patient's needs.

All team members were aware of their responsibility for each individual patient's care. This ensured treatment was consistently delivered in a coordinated, person centred and supported way. This was evidenced in the patient's care plan and notes. Staff knew the patients they were supporting identifying their needs and which other 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 patient 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. This included communication and discussions regarding equipment provision to ensure patients returned to an appropriate environment. For other patients a discharge process involved liaison with social care services, therapy teams, families and individuals who may care for the patient. We saw evidence of a coordinated discharge process undertaken with other services to ensure continuity of care and a stable support network being in place for when the patient was discharged.

Seven-day services

The service provided seven-day services. Staff from all therapy disciplines were available to ensure the continued delivery of patient's ongoing rehabilitation at weekends.

For medical care the service had on call registered medical officers out of house who would respond to staff requests for assistance. The medical director for the service was a consultant and available to offer staff support.

In the event of a patient requiring nursing care over and above what could be provided by the service, the patient would be referred to their local acute hospital, approximately two miles away.

We saw appropriate emergency referrals were made when required. For example, a patient had recently suffered a serious health decline. Advice had been sought on how to manage their presented symptoms however nursing staff were concerned, so an emergency referral was made to the local acute hospital where they were transferred to receive the emergency care they required.

Health promotion

Staff spent time with patients when they were admitted to the service to explain the process of their rehabilitation and agree expectations. Staff took time to understand the patient's lifestyle prior to admission and used this information with patients when setting their goals, this meant they were realistic and achievable.

The service identified patients who needed extra support, such as patients who would need stop smoking advice or had dietary requirements. The team supported carers as well as people who lived with the patient identifying what to expect and how to support the management of long-term conditions. As an example, the speech and language therapist supported patients with communication needs and how they may address these in a community setting.

Patients were involved in regular monitoring of their health and were educated as to what signs to identify which would indicate they required further support. This education was done during therapy sessions as well as using booklets and providing patients with contact details of relevant charities who could support them in their aim for better health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

During the inspection we observed staff evidencing their awareness and application of the Mental Capacity Act 2005 (MCA). The MCA code of practice states all practical and appropriate steps must be taken to ensure patients are able to make a decision for themselves. We saw staff requesting patient consent throughout their interactions, regarding care and therapy choices the patients were due to receive and why. This enabled patients to make an informed choice regarding if they wished staff to continue.

Staff were aware of a patient's right to make unwise decisions which would include withdrawing from therapy

or making unwise decisions which could impact on their health or wellbeing. Staff identified they would offer support and advice for patients however, any decision, if they were deemed to have capacity, was their right to take. In the event of unwise decisions being made staff created risk assessments to ensure any risks to a patient's wellbeing as result of their unwise decision were minimised.

Staff provided examples of when they had sought support from a clinical psychologist when they had concerns regarding a patient's ability to make informed decisions or consent to any aspect of their care. This included concerns being raised regarding a patient's request to have a feeding tube removed. Records evidenced a mental capacity assessment had been completed with the patient and the psychologist had spent time making sure the patient could communicate clearly their wishes. A decision had been reached with the healthcare professionals involved in the patients care within and outside of the hospital, including their GP and family members. It had been identified the patient did not have the capacity to make the informed decision regarding that particular aspect of their care and their feeding tube was not removed. This decision had been in the patient's best interest to maintain their health.

Senior staff could describe the process of applying for a Deprivation of Liberty Safeguards (DoLS) to keep a patient safe. The DoLS is the procedure prescribed in law when it is necessary to deprive of their liberty a patient, who lacks capacity to consent to their care and treatment, in order to keep them safe from harm. We saw appropriate applications were in place which included when providing one to one care but only for such time as deemed necessary. For example, one patient had moved to the service with a DoLS in place as previous care staff felt the patient was unable to keep themselves safe. The service sought to find the least restrictive option to keep the patient safe without subjecting them to continual monitoring. The patient had commenced with one to one monitoring however the one to one care was gradually removed whilst other, least restrictive measures were put in place to keep the patient safe.

Are community health inpatient services caring?

Outstanding ☆

Compassionate care

During the inspection we saw positive, caring, friendly and encouraging engagement between staff and patients. Patients were continually positive and told us they were encouraged to be as independent as possible by staff who provided their assistance in a sensitive and respectful way. We saw examples where staff had exceeded what was expected of them in their roles to ensure patient's emotional wellbeing needs were met and patients experienced truly personalised and compassionate care. There was a culture amongst the overall staff team of providing care in a holistic approach which focused on ensure patient's emotional wellbeing needs were met over and above their physical needs.

Staff understood and incorporated the personal, cultural and social needs of patients into their care plans. Patients told us they felt staff teams worked together to ensure their needs were met and exceeded these on occasions. We heard examples where patients had been accompanied by staff when they had been taken to hospital to offer reassurance in unfamiliar surroundings. One patient had enjoyed music therapy sessions whilst in the service, once they had been taken to hospital staff ensured the music therapist visited them to offer comfort which had been recognised and acknowledged by the patient. Other patients had been supported to celebrate life events and experiences such as birthdays, weddings and trips away from the service by staff who had identified and sought ways these experiences could be experienced by patients to their full potential.

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 warmth and interest in patients' wellbeing. Care and therapy was delivered by staff in a way which evidenced it was completely focused on the patient's wellbeing, despite staff being busy, all care and therapy was given in a completely personalised and compassionate way with no sense of rushing. Relationships were not identified as staff and patient but all worked as a team to achieve common goals.

Staff continually engaged patients to participate fully in their therapy sessions. Positive encouragement was used to congratulate patients when they achieved each step of their therapy session. Touch support was used to ensure patients were engaged in conversation with their therapist during their sessions. Where patients were finding therapy difficult to complete they were comfortable to use humour with staff which showed genuine relationships had been developed in the sometime, short time, patients had been at the service.

Staff demonstrated a caring attitude and evidenced patients' privacy and dignity needs were understood and respected. This included asking patients if they were well and needed anything during all interactions, knocking and awaiting a response before entering patient rooms and enquiring on their wellbeing in a discreet way if evidencing signs of discomfort during their therapy sessions.

We saw staff took quick action to respond to patients who were experiencing physical pain, discomfort or emotional distress. During a therapy session one patient being supported to stand exhaled heavily indicating they were finding the movement difficult. Staff responded immediately to the patient's response and stopped all movement enquiring about their wellbeing and placed them in charge of what action they took.

Nursing staff also responded positively to ensure patient's discomfort was minimised wherever possible. During a period of prolonged and extreme heat a patient had mentioned they were uncomfortably warm despite a fan being made available. Staff fetched the patient an ice pack to ensure they could remain comfortable, this action allowed the patient to sleep undisturbed.

Emotional support

We saw staff automatically considered carers and families emotional needs in addition to the patients' needs. Patients and families were empowered to access counselling services through the services commissioned clinical psychology services. Staff evidenced they reviewed patient's wellbeing as a whole and managed their emotional wellbeing also encouraging they meet their social needs. This included encouraging patients and their families to eat in dining areas to create a social atmosphere and supporting patient's friends and families to become involved as part of the patient's therapy process. This ensured patients were supported continuously by their family members once their rehabilitation journey had finished at the service.

Patients told us they were regularly offered timely support and information to cope with their emotional care and treatment. One patient confirmed staff were available to them to talk about their needs including emotional needs whenever needed. Staff said the hospital used the services of a volunteer from the spinal injuries association who would speak with patients with spinal injuries and would also offer family support. The volunteer ran peer support groups and encouraged patients and their family members to participate in these groups to share their experiences, fears and hopes moving forward with their care. The staff recognised the importance of ensuring patient's were able to share their experiences and seek the emotional support they required to continue their rehabilitation.

Staff ensured patients emotional wellbeing was met and consistently monitored. Patients were empowered to talk about how they felt and share concerns they may have. Staff continuously asked patients how they felt at the beginning of any intervention, assured patients they were in control and if they did not feel they could continue to talk with them. If required alternative treatment would be offered to ensure the patient felt they were in control of all aspects of their care and rehabilitation.

The service recognised the importance of ensuring patient's received family support to and facilitated the ongoing of family and patient relationships. Patients could be visited by friends and family with limited restriction on their visiting times. To ensure all patients were able to have restful sleep, friends and family could readily visit between 10am and 10pm each day. Where patients had family or friends who could not visit in the time frame agreed procedures were in place to ensure the patient's social and emotional wellbeing needs were met without impacting on other patient's. The service also offered private apartments with self-catering facilities which were available on site. These provided privacy for patient's friends and family to visit without restriction.

Understanding and involvement of patients and those close to them

Requires improvement

Community health inpatient services

Patients were treated with respect and all staff teams worked together to support patients to manage their own health, care and wellbeing to maximise their independence.

We saw patients and their families were actively encouraged to attend case conference meetings. Staff worked to ensure patients, their carers and relatives understood and agreed with the treatment and therapy options being suggested. These meetings helped all parties understand patient's individual preferences and how to best deliver highly individualised tailored care which reflected the way the patient liked to be treated.

We saw staff continuously communicated with patients in an understanding and caring way. They recognised the need to adapt their communication style according to the patient they were supporting to ensure they were engaged in conversation. During a therapy session a younger patient was being supported by staff, the conversations were personalised, showed detailed knowledge of the individual and were jovial with all involved engaged and enjoying the interaction. With an older patient staff changed their communication style so their voices were slightly louder, slower and offered the patient additional time to process what was being said to them. All conversations matched the patient's pace of communication. Patients were provided with the opportunity to have their voice heard throughout all aspects of their care enabling them to feel at the heart of the work which was being completed to support them.

Staff also interacted well with patient's family and friends. We saw patients' visitors were welcomed and relaxed information conversations were held evidencing regular contact. One relative told us they were very happy their family member was a patient at the hospital, "The key to that (happiness) is the staff, (we) have developed very reassuring relationships with people". We saw staff explained to patients what was happening with their care and therapy so they understood what was happening and were part of the decision-making process.

Staff sought accessible ways to aide communication with patients who were unable to verbally communicate due to their illness or disability or who did not have English as their first language. Staff told us they had picture boards to aide communications and could use other staff members or families to translate, if the patient agreed.

Staff recognised patient's ability to communicate clearly could fluctuate depending on their emotional wellbeing and evidenced they could meet this changing need. For example, the service cared for many patients who lived in Arabic speaking countries, for a number of these patients English was their second language. Patients, when they were tired or unwell would often return to their first language. To meet these needs the service employed the services of a Arabic speaking speech and language therapist, both resident medical officers and a number of other staff could speak Arabic. This ensured there was no barrier stopping patients from interacting clearly with staff.

Patients said they felt empowered and supported during their rehabilitation process and felt it resulted in a positive impact on their health and wellbeing. Patients told us 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 patients were at the centre of their therapy and evidenced an inclusive attitude towards all parties being involved in the patient's 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. Therapy staff told us relatives had regular access to staff and involved all parties important to the patient in their care. This included being actively involved in their physiotherapy sessions. Patient's friends and family were encouraged to "Drop in" and ask questions as there were named occupational and physiotherapy staff in place for each patient allowing for easy and knowledgeable points of contact.

The service took steps to protect confidential patient information. Patient held folders accompanied the patient as they moved around the hospital, this ensured their personal information was kept confidential and could not be read by patient's families or friends without their knowledge or consent.

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 sensitive information was only shared with consent from the patient.

Requires improvement

Community health inpatient services

When required, the service could support patients to have a comfortable and dignified death. The service supported patients on their rehabilitation pathway to enable them to achieve their goals towards independence following injury or illness. However, there had been situations where patients' health had declined following an illness and upon request family members asked for them to remain at the service. The service was able to meet these requests as the consultant could prescribe the appropriate medicines to ensure the patient remained comfortable and pain free. In these rare instances end of life care plans were put in place written in conjunction with family members whilst acknowledging patient wishes.

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

(for example, to feedback?)

Good

Service delivery to meet the needs of local people

The services provided reflected the needs of the population who accessed the hospital. This included maintaining an awareness and practice of cultures associated with the overseas patients the service supported. We saw patient's individual needs and preferences were documented to allow for the delivery of personalised care.

The service provided engagement and involvement opportunities for patients and those close to them through day to day interaction, multidisciplinary meetings and by ensuring management was available to discuss any service issues with the patients and their families. Each patient had their own timetable which was discussed and agreed with them upon admission and the service was tailored to meet their own individual needs. Patients could dictate their aspects of daily living including the time they rose, when they wished to have their personal care needs met, any additional support they required during the day and what they ate for example.

Facilities and premises were appropriate for the services being delivered. Staff could make use of individual therapy rooms or use of the rehabilitation gyms. There were also kitchenettes on each patient floor with equipment to assist patients in developing their independence and regaining confidence in a safe and protected way.

Most patient rooms had ensuite bathrooms to enable rehabilitation to be promoted and actioned as part of their personal care routine. The service also offered self-catering private apartments to more independent patients, their friends and family. These allowed patients to have a safe environment which promoted independent living prior to community discharge but still have access to a level of assistance which would assure their long-term needs were addressed.

Patient's had access to staff and services which would aide translation for those who had difficulty understanding or speaking English as it was not their first language. The service had a number of staff with second languages including Arabic and Romanian staff and commissioned services from other healthcare professionals such as speech and language therapists and dieticians who could speak Arabic and Chinese. If required, the service had access to interpreter services to enable patients to interact unhindered with staff.

Patients were supported to review legal documents and other documents of importance as they could be translated into their language of choice if required. The manager told us this work was normally undertaken by the patient's insurance company paying for their care however, the service had access to independent translators who could complete this work on patient's behalf. The service also had the ability to liaise with patient's home country's embassy to seek this support if preferred. This would ensure patients could to readily understand any information provided and generated as part of their care and therapy.

The service was in the process of redesigning and expanding the hospital at the time of the inspection. Permitted preparatory work had commenced, however and was being completed in a way to minimise the impact on the wellbeing of the patients at the service.

This work had included the redesign of a patient's living area on the ground floor to make it homely in appearance and accessible to all. Signs were placed around the service to enable those patients who were independent with their mobility to move around the hospital without

assistance. Stairwells were well lit, clear from clutter with handrails to assist independent walking. Whilst the stairwells were tired in their appearance with carpet and wallcoverings requiring replacement this was part of the overall strategy in improving the patient's overall living environment. Patients were to be included in the redesign and decoration of the service once the initial approval for the major building works had been agreed.

Patient's individual cultural or diverse care needs were discussed with patients during their preadmission. This preadmission included information on how to meet these needs sensitively. Staff told us this information was made clearly available to them when the patient first moved to the service so their needs could be met as soon as they were admitted. This included ensuring patients of different religious faiths could have their religious needs and beliefs practiced without impacting on other patients. For example, ensuring lights were offered to be turned off when it was reaching dusk or moving their beds in accordance with their wishes. Patients were also supported to practice their faith and timetables were created allowing patients time to pray when required. The service also initiated contact with local churches to ensure patient's could have visits from a member of their local religious faith to ensure they could continue practicing their faith.

Meeting people's individual needs

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

The service used multidisciplinary assessments to identify and meet the information and communication needs of patients with a disability or sensory loss. Assessments were recorded in the patient's care plan, highlighted and shared with professionals involved in the patients care.

The service had access to adapted communication systems such as picture boards to support patients to be able to communicate more effectively. For patient's unable to verbally communicate the service had identified the most appropriate way to ensure ongoing interaction. This included documenting and practicing a communication system which focused on the movements a patient could make with their eyes. We saw evidence this information was clearly displayed for staff and was followed during the inspection.

The service discussed how they would be compliant with the accessible information standard when required. Since the new manager had commenced with the service in April 2018 there had been no need to source information for patients in alternative languages or large print. If, during preadmission stage it was identified this was required, the manager knew how to source this information. This included seeking information written in braille and information in audio formats to support patient's needs.

The service could source specialist equipment to support patients who had additional moving and handling need or required support to maintain their skin integrity. This included bariatric equipment for example. The services hoists could meet bariatric patient's needs and if required bariatric bed and shower chairs for example could be sourced within 24hrs and be in place prior to patient admission. The service offered specialist air mattresses for patients who had been admitted with pressure sores and required specialist support to aide their skin healing.

Patients were supported during referrals, transfers between services and discharges. The team assigned to the patients' rehabilitation programme were introduced as soon as possible and explained their scope of practice and proposed therapy programmes.

We were told communication between services prior to admission was completed with the use of preadmission assessments so vital information regarding 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 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. Staff said this was important because it helped support the rehabilitation programme and promote patient independence.

Access and flow

Requires improvement

Community health inpatient services

Patients were moved to the service following a detailed preadmission process to ensure patients referred to the service were appropriate for admission and could have their needs met by staff. In the event of patient's presenting with an illness or injury which had not been previously been cared for by the service, staff received appropriate training in this area at the earliest opportunity. This ensured the patients had timely access to treatment from qualified staff as soon as they were transferred.

For example, a patient on the waiting list to transfer to the hospital had specific needs which had not been previously accommodated. As a result, a multidisciplinary approach was taken in preparing appropriate care plans. This information would be sent to the relevant ward so timely treatment could be delivered as soon as they moved to the service.

At our last inspection in April 2016 we recommended the provider reviewed their admission procedure so out of hours admissions were properly managed, to ensure they could meet patient's needs and promote their safety and comfort. At this inspection we were told patients would not move to the service until they had participated in the full pre-assessment process and it was known they could have their needs met by staff as soon as they moved. For patients who chose to move to the service on a Sunday to start their treatment on a Monday morning the service now had a member of therapy staff working over the weekend. This ensured if there were any changes to a patient's mobility post preadmission and prior to moving to the service the therapy member of staff, in conjunction with the trained nursing staff, could reassess the patient to ensure their immediate needs were met.

Patients were encouraged to participate in two occupational therapy and two physio therapy sessions a day from Monday to Friday with at least one session at the weekends. Therapy timetables were completed in conjunction with patients and sessions changed or moved to accommodate patient needs. For example, patients who slept later into the morning or required additional care support in the mornings had later therapy appointments which met their needs.

Learning from complaints and concerns

Patients and relatives who used the service had access to information on how to make a complaint and staff who encouraged patients to raise concerns and complaints when identified.

The service had a 'Complaints, Suggestions and Compliments Policy and Procedure' located in the publicly accessible reception area to the hospital which provided guidance on how to raise concerns and complaints. There were also opportunities for patients, their friends and family to raise concerns and complaints using comment cards and boxes. These were situated at the entrances of the lift and in the public foyer of the service so were visible to all.

The service's policy and procedure contained information regarding the types of concerns and complaints which could be raised and how they would be responded to. The policy also included timescales for acknowledgement and completion of any complaints investigation.

The service aimed to acknowledge the receipt of a complaint within three working days of receiving it and respond to all complaints within 28 working days. Patients were advised investigation completion dates could be extended but this would be agreed in advance.

The service reported 14 complaints between the reporting period of December 2017 and August 2018. There were no complaints referred to the Parliamentary Ombudsman or Independent Healthcare Sector Complaints Adjudication Service in the same reporting period.

Other than a number of concerns raised around a heating issue which was resolved by the purchase of additional heaters whilst the central heating system was flushed, there were no repeated themes. We saw all, bar one, complaint were resolved at a local level either on the day the complaint was raised or within 28 working days in line with the service policy and procedure. For a long-standing complaint, we saw this had taken three months to resolve however, there had been regular updates with the complainant to advise them of the progress of the investigation.

Requires improvement

Community health inpatient services

Results of complaints and learning identified were discussed in team meetings to ensure events which led to the complaint were not reported. We saw evidence of complaints being handled in an open and transparent way whilst ensuring confidentiality.

Are community health inpatient services well-led?

Requires improvement

Leadership

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

Staff knew who the management team members were and said they were visible and approachable. Staff spoke positively of the management and board changes which had occurred within the last year. Staff told us they felt comfortable in approaching the board and the management team if they had any questions, concerns or required support.

We saw interactions between managers and staff, these appeared to be open and supportive. The management team were a visible presence on the wards, in the service and during handovers where they took actions to support staff with patient care. During the inspection we saw patients were comfortable in approaching the management team to discuss issues of importance to them.

The management team understood the challenges to quality and sustainability for the service and were addressing these issues. The new manager had been with the service for approximately four months and had been reviewing working practices and procedures during this time. They had identified the need for improvements in the provision and completion of care and risk paperwork and had been working to address these by implementing changes. They were also working with the service's board members reviewing staff pay and conditions to increase morale, reduce staff sickness and ensure the ongoing recruitment of high quality staff members.

Vision and strategy

The service presented a set of values which included quality and sustainability within the overall service goals of, 'Care, management, innovation, training'. The service had a vision statement to emphasise how they wished to deliver services, this read, 'To provide transformational care and rehabilitation with compassion'.

The service's objectives were to work alongside patients to equip them to live their lives, fulfil their maximum potential and optimise their contribution to family life, their community and society. The service wanted to achieve this by working in partnership with patients and those important to them so they could maximise their potential, independence and have choice and control over their own lives.

Staff we spoke with could not accurately describe the service's visions and values however, recognised the objectives of the service was to deliver high quality care to support patients to achieve their rehabilitation goals. One member of staff said of the services values, "It's innovation, inspiration, integration". They described the values as supporting innovative techniques and technologies to improve patient mobility as well as being a centre of excellence, allowing staff to grow and "Making sure everyone is valued and that they have a place here, both staff, patients and relatives involved and we're involved".

The service had recently redeveloped their vision and values and recognised more work was needed to ensure staff understood what the new visions and values meant to them. This was to be supported from the interview stage for new staff ensuring interview questions were aligned to fit with the service's visions and using them to measure staff performance.

The service had a clear five-year strategic business plan which had been put into place in June 2017. This development plan detailed how the service was to develop in line with their vision statement and identified the strengths, weaknesses, opportunities and threats to service delivery with plans in place to meet any identified areas. This plan was however under review whilst the service reviewed their service model.

Culture

We saw the culture within the service was one of pride in their work and a desire to deliver high quality care. Staff

told us they felt positive and proud to work for the service and felt all teams pulled together to meet patient needs in the transitional model of care the service was keen to deliver.

All staff spoke positively about the culture of the service and shared their views of what they felt were the strongest attributes of the service and staff. Staff consistently felt they were part of a hard-working team who were working with the same goals and objectives, which were to improve the health and wellbeing of the patients they supported. Positive staff comments received included;

- "(I've) never worked anywhere where everyone is so nice to each other…everyone is part of the team from the cleaner to the manager…it's the nicest place I've worked, it's like being part of a family".;
- "I love it here, I absolutely love it here, I just love the people and the patients, we're a good bunch of staff."
- "Nursing and therapy care is second to none…there's only two places I would want my relative to be at and this is one of them, that's the one thing you need to ask, would you have your mum here, would you have your relatives here, and I would."
- "When needed, you're a family and that's what I get from here, I feel it's a family."

Staff felt supported, respected and valued. They said their managers were very supportive, approachable and accessible whenever required. All staff we spoke with said they had a singular shared aim, to ensure patients left the service achieving what they initially thought was impossible at the start of their rehabilitation journey.

The service provided mechanisms for development of staff at all levels. These included appraisals, supervision and open discussions with 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 management team.

Governance

There were effective structures and systems of accountability to support the delivery of good quality, sustainable services. Each ward was led by a sister who was managed by the clinical nurse specialist and deputy manager. There were separate governance arrangements for health care assistants and therapy staff, however all were aware of their management structure.

The service had processes in place to review the quality of the service provided and ensure information discussed was shared with all members of staff. This was completed through board meetings, clinical governance meetings, senior staff meetings, MDT meetings, nurses' forum, carers forum and general team meetings.

The service reviewed the quality of service provided by visiting health and social care professionals to ensure patients received the most appropriate care which met their needs. An annual conditions review meeting was held where service delivery was discussed to ensure it continued to meet patient's needs. To increase the level of interaction with these providers the manager was encouraging their participation in weekly MDT meetings.

The services Managing Director maintained an overview of the professional registration of consultants, and any other medical professionals, not directly employed by the service, to ensure they continued to work within their identified practising privileges. The service's clinical administrator documented these staff members training details, DBS and insurance details to ensure they remained appropriate to work with the service.

Managing risks, issues and performance

The service could not evidence comprehensive systems and auditing processes were in place to identify key risks to service provision to ensure they were managed appropriately.

The manager had joined the service in April 2018 and had started making positive changes to service provision including the introduction of new care and risk assessment paperwork. There were other areas for improvement noted during this inspection, however which had not been previously identified and action taken to minimise risk to service provision.

It had been recognised by the nominated individual and new manager, governance and risk management processes required reviewing and a 'High Level Project

Implementation Plan' was in place to meet these needs. This plan included an action plan which had identified some of the areas of improvement identified during this inspection.

This included ensuring service had implemented a project to improve the quality and governance structure and modernised and made fit for purpose quality assurance process. Work streams had been agreed with project leads, the heads of department involved, the start and target date for completion of this work. This was ongoing at the time of the inspection and was anticipated to be completed by the end of September 2018.

The service used a variety of methods to store important information about service provision, however, the service could not assure these methods were always accurate and accurately documented service provision.

The service used an accident and incident tracker (to be referred to as 'the tracker' throughout the remainder of this report) which we reviewed for the period January 2018 to August 2018. This was manually completed and detailed incidents which occurred within the service including falls, accidents, infections and safeguardings for example.

The service also used and electronic software system which produced a monthly quality dashboard report which reviewed the service's performance against key safety measures including infections. The quality dashboard was created by the submission of online information and produced monthly reports which reviewed key safety measures including the number of falls and patient infections for example. There were, however inconsistences between the service's tracker and the dashboard information.

The service's quality dashboard identified between January 2018 to July 2018 inclusive there were 16 accidents, 23 incidents, nine adverse clinical events, nine infections and three pressure sores. This amounted to 60 accidents/incidents. The service's tracker however, only registered 52 incidents for the same time period.

The service's quality dashboard identified all incidents had been reported appropriately however, information on the service's tracker did not correlate. The service therefore could not assure itself each incident had been investigated and responded to appropriately.

The service's tracker identified one patient had suffered an infection in April 2018, however the quality dashboard report had identified nine reported infections for the same time period January 2018 to July 2018. These nine infections included two chest infections, one positive MRSA finding, one case of Klebsiella pneumoniae and one instance of Pseudomonas.

We advised the service of the discrepancy between the number of infections reported on the service tracker and number of infections reported on the quality dashboard. The service responded by providing a revised dashboard and tracker however, the resubmitted figures still did not match.

Staff were encouraged to raise concerns during their team meetings and we saw, since the introduction of the new manager, these meetings had been completed monthly and were widely attended by all staff. The service management team knew when to escalate issues to the board group if required.

The service identified key areas they required to be audited on a monthly basis, this included, infection prevention and control measures, staff information, patient information, health and safety and documentation. For the period January 2018 to August 2018 an audit calendar identified 101 audits should have been completed however, 24 audits of these proposed audits had not occurred.

The provider's quality and compliance manager acknowledged there had been gaps in the audit schedule, however there had only been on occasion where two consecutive months' worth of data had not been audited, patient information on the Rothchild ward for April and May 2018.

The audits showed the lowest compliance rate for any aspect of service had been 71% for compliance with staff information in March 2018 for the Nightingale Ward. Action had been taken as a result and compliance in the following months audit identified a marked improvement of 91%.

Audits were used as a means to improve the quality of service provision, however had not always been effective in identifying shortfalls in patients' risk assessments and staff training data.

Requires improvement

Community health inpatient services

The service did not have fully implemented and robust arrangements to identify, record and manage risks. The manager told us the service did not have a risk register to document risks as they were a small hospital. The service's quality and compliance manager said a corporate risk register was in the process of being created which would capture all key risks in service provision and any identified risks to the overall business with mitigating actions documented.

Until the introduction of the risk register risks were managed through the clinical governance meetings process. These were due to be held monthly, however, due to the quality and compliance manager supporting the hospital's sister service were only being held once every three months. These reviewed the outcome of the service's dashboard and key service performance areas.

The providers quality and compliance manager had joined the service in January 2018. Their role included reviewing the quality of service provision and identifying and managing risk. When they joined the provider, however they were required to provide support at the hospitals sister service which had impacted on the role they were able to perform.

The previous registered manager left the service in January 2018 and whilst support had been provided by the service's deputy manager and the nominated individual, it had not been possible to complete all the service's planned regular audits to assess the quality of service provision. These issues had been addressed with the recruitment of new staff and action had already been taken to implement more regular and consistent monitoring the quality of the service provided.

The service had started to implement an electronic system to maintain an overview of the quality of service provision. This system would provide a clear view of quality, be accessible and used by all staff, provide clear instant reporting on audits and provide live data aligning actual data against identified key performance indicator. This would automatically highlight any potential risks such as failure to deliver a service at the required time.

Staff were involved in discussions regarding how this electronic system would best meet the needs of their service. For example, lead therapists had requested additional questions which would support obtaining information for their outcome measures which was being discussed with the provider. This would enable the service to have a bespoke system to gather, store, review and review all aspects of service provision, risk identification and risk management.

Managing information

The service reviewed quality and sustainability in clinical governance meetings. These had been held three monthly owing to other provider's priorities, however with new managerial staff in place, were due to take place monthly.

The service did not have clearly defined and formalised key performance indicators (KPIs) to allow of the monitoring of its overall performance. The service had identified key risks associated with patient care including safeguarding incidents, accidents and other incidents which were reported on weekly, however had not introduced KPIs to monitor the quality of the service provided.

The service used patient centred outcome measures and customer feedback to measure qualitative information. This gave management insight into how patients experienced their rehabilitation and how they felt about their progress but did not provide an overall view of how the service was operating.

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

The service sought patients views and experiences to identify where positive changes could be made to improve service quality. Management teams engaged and involved staff in discussions regarding future and potential changes to the service.

Staff and service users regularly engaged in feedback on how to improve the service and accommodate patients' needs. We heard examples of staff and patient requests which were being incorporated into the service's development.

These included patients and staff identifying more social space would be beneficial with better outdoor access. Patients had also identified, in a patient forum, they were

not confident using wheelchairs in the community and felt they did not have the outdoor space available to practice their newly acquired skills. Following this feedback, development plans of the hospital included landscaping to the front, rear and side of the hospital. This would enable patients to practice on an external flooring environment supporting them to develop their skills and provide them with confidence to access the community independently.

Staff told us patients had access to patient questionnaires and feedback forms which were discussed at monthly staff meetings and departmental meetings to identify how service improvements could be made. Patient satisfaction and feedback surveys were handed to all patients as they left the service. These were analysed and identified where patients were happy with the quality of the service received and where they felt improvements could be made. These were reviewed by managerial staff before discussion with the provider's quality and compliance manager.

We viewed a number of these completed surveys which asked patients to rate their nursing team, therapy team, medical team, catering, administration and managerial team, 'excellent, good, acceptable, poor' in a number of key areas. These included, the teams ability to make them feel at ease, ability to enable patients to maximise their independence, treating to them in a timely manner and asked how they found their overall experience.

All surveys viewed highlighted patients rated 'good' or 'excellent' all aspects of the care their received. Positive comments were received which detailed what patients had found good about their hospital stay. These included, 'This was the first time I believed I really could become fit and mobile' and 'Staff and treatment'.

Other written positive feedback and thank you cards from many former patients had been received and included some of the following feedback;

- 'The therapy offered is very client-centred and dignified…they (staff) listened to (family member) were very inclusive, explored their wishes and offset these against potential risks. The Royal Buckinghamshire is currently a great example of how quality and service delivery still mean one and the same thing'.
- 'Thank you so, so much for helping me begin to regain my fitness, your encouragement, advice and expertise has helped so very, very much both mentally and physically' and
- 'I attended with some reluctance and a lot persuasion, I am so grateful to every member of the team who treated me and all the kindness of those who didn't. A massive thank you to you all'.

The therapist team had also been nominated for the 'Outstanding Team Award' in the spinal injuries association 'Rebuilding Live' awards in June 2018. This celebrated the achievements of the spinal cord injury community and was used as a way to say thank you to those who had made an impact on the lives of others.

The managerial team were a visible presence on the ward and through friendly and familiar conversations saw they knew their patients as an individual. This presence presented friends and families with the opportunity to talk about patients care and provide informal feedback regarding service delivery.

Through this process the service had received feedback regarding the quality of the food provided. As a result of this feedback the service had employed a new head chef who had met with patients, sought their preferences, identified patient needs and expanded patient's food choices to accommodate their wants.

Staff engaged with management and provided feedback to the executive team through a variety of regular meetings, this included, heads of department meetings, nurses and healthcare assistant forum and monthly team meetings. This enabled staff to interact openly with management and allowed information to be raised through these processes to the provider's board and messages to be returned.

For example, staff identified they wanted to move away from patient's eating in their rooms to make it a more sociable event. Staff expressed they felt it was beneficial for patient's social and therapy journeys if this could be accommodated. The hospital had social spaces available for patients use but with limited furniture to support use as dining areas. Following staff feedback work was ongoing to purchase large tables which would enable patient's in mobility equipment to access and join others for meal times.

Learning, continuous improvement and innovation

There was a focus on learning and improvement, including through appropriate use of external accreditation and participation in research.

Management team supported staff to ensure continuous learning, improvement and innovation by providing them with opportunities to escalate personal development needs through appraisals and supported business cases. There was a focus on sharing learning and best practice and the service made financial provisions available to encourage innovation.

The service participated in research projects and staff had been supported to visit foreign countries to participate in conferences. This included a spinal injuries conference held in Mauritius where staff used the knowledge gained to share best practice and provide learning opportunities in less developed countries. In 2017 staff had supported the learning of how to splint patients appropriately using available materials and were currently developing learning on how to help teach women to make their own pressure cushions.

The service utilised staff skills and specialities to share learning whenever possible. Staff were also able to request external specialists to provide teaching and learning, for example, in 2019 a specialist from Brazil was attending the hospital to share learning on proprioceptive neuromuscular facilitation (PNF). PNF is a method of physical therapy specifically designed for patients who have suffered a stroke to improve their strength, mobility, coordination and stabilisation.

The manager had created an innovations group. When they moved to the service in April 2018 they identified there was an ad hoc approach to requests to participate in research and try newly developed equipment. In October 2018 the staff's innovation group was due to hold its first meeting. This would allow staff to bring projects they wished to participate in and equipment to the group where discussed would be held about which would be most beneficial for patients at the service.

Staff were proactive in identifying new ways to support patient's needs. A member of staff was working on an outpatient gym project. They had identified patients moving on from rehabilitation felt they faced barriers when attending their local gyms. As part of the future development plans of the service they were assessing the possibility of operating an outpatients' gym in the hospital. This would be run by a personal trainer but overseen by therapy staff. This would enable staff to teach spinal injury patients what they would be able to achieve in a community based gym environment allowing them to progress their rehabilitation.

The service recognised the need to offer encouragement and reward staff for their work. Staff were presented with chocolates or flowers to say thank you and received public praise for their work in staff meetings. The service was reviewing all pay structures and seeking to offer staff an incentive package to thank them for the work completed.

Outstanding practice and areas for improvement

Outstanding practice

- We saw an embedded practice of person centred care with staff highly motivated to provide care respectful of patient's privacy and dignity. Positive relationships were created and nutured to ensure patients fully engaged with their rehabilitation journey.
- Continuous positive feedback was received and viewed which praised staff for their caring nature.
- Friends and friends important in patient's lives were actively encouraged and supported to be part of their rehabilitation journey enabling them to continue being involved in the patient's recovery once discharged from the service.
- The care provided to patients was outstanding, patient's were supported by staff who had an embedded culture of meeting their emotional and physical needs. Patients were empowered and offered with opportunities to share any emotional concerns they had.
- Staff took the time to develop genuine, warm and respectful relationships with patients to ensure they felt fully supported throughout all aspects of their care and therapy.
- Staff exceeded what was expected of them in their roles to ensure they recognised and took action to ensure patients received highly individualised and compassionate care. Staff went over and above their roles to offer care to patients so they could experience important and significant life events.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure risks to patients are appropriately identified, assessed with sufficient detail to minimise the risk identified and followed by staff.
- The provider must ensure risk assessments and care plans are reviewed and updated in accordance with patient needs and provider policy.
- The provider must ensure staff receive the safeguarding children training as per the requirement of their role when working with parents and carers of children.
- The provider must ensure systems in place to capture, document and detail response to risk are accurate, completed at the identified timescales and updated appropriately.

Action the provider SHOULD take to improve

- The provider should ensure systems in place to monitor staff training compliance rates accurately reflect staff training data.
- The provider should ensure staff are aware of the service's visions and values for the development of the hospital.
- The provider should continue to develop their programme of audits to ensure they identify areas of service improvement

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance Detailed processes must be in place to ensure risks to patients health and wellbeing are identified with clear actions to mitigate the risk identified and followed by staff. Staff must complete accurate complete and contemporaneous reviewing and recording of patients records in line with provider guidance. Effective systems and processes must be in place to ensure risks to service delivery are appropriately identified and mitigating action taken to address these. Regulation 17 (1)(2)(b)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing Staff must receive appropriate safeguarding child training as required to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

Regulation 18(1)(2)(a)