The Raphael Hospital

Quality Report

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Date of inspection visit: 15 January 2019
Date of publication: 15/04/2019

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?	**Requires improvement**
Are services caring?	**Good**
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.

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.

Summary of findings

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

Overall summary

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

The long-term conditions service at the hospital focuses on the care, treatment and rehabilitation of people with acquired brain injuries. There are facilities to accommodate a total of 60 patients. There is space for 31 patients in two wards in the main building and 21 patients in Tobias House which is designated as an area for the treatment of prolonged disorders of consciousness. There is a further capacity to treat eight patients in the special care unit for neurobehavioral rehabilitation and this unit also accommodates patients admitted under the Mental Health Act. Facilities available at the hospital included a physiotherapy gymnasium, a hydrotherapy pool, therapy rooms, consultant rooms and common areas.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 15 January 2019.

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

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

Services we rate

Our rating of this hospital/service stayed the same. We rated it as Requires improvement overall.

- The service did not have managers at all levels with the necessary experience, knowledge and skills to lead effectively. The main house was managed by an experienced ward manager who had been in post since 2015. However, during inspection it was identified that three out of four of the wards did not have a ward manager.
- Managers could not demonstrate adequate systems and processes that assured us they had full oversight of the service in terms of risk, quality, safety, and performance.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care, but there were areas that were not fully effective.
- The systems used to identify risks, and eliminate them, were not always carried out in a timely manner. Although there was a risk register, there was no robust way of ensuring effective risk reduction strategies had been undertaken, or potential risks not fully recognised.
- The service provided mandatory training in key skills to all staff; however, not all staff were up to date with their training.
- Infection control issues identified in the last report remained. Although there was a plan to make changes, the pace of making sure compliance with infection control regulations was slow.
- The service generally had suitable premises, but the design, maintenance and use of facilities and premises did not always keep people safe.
- The service audit programme was not robust; although audits were undertaken, non-compliances were not always rectified and we saw the same non-compliances repeated on multiple audits.

Summary of findings

- Staff and patients did not always have access to call-bells to get help. Communal areas such as the lounge, activity room and corridors did not have call points available
- Emergency buzzers were available, but staff we spoke with were unaware if these had been tested or whose responsibility this was.
- Staff on the special care unit were not able to communicate effectively, particularly in an emergency. Two-way radios were available, but we found only two were working and of the two working radios, only one could make and receive calls.
- Best interest meeting notes, were not completed consistently, and the least restrictive option was not always clearly identified.

However:

- Staff in different roles worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide care. Staff respected their colleague's opinions.
- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise distress. Staff were on hand to offer emotional support to patients and those close to them. Patients told us they felt able to approach staff if they felt they needed any aspect of support.
- Staff involved patients and those close to them in decisions about their care and treatment. We saw effective interactions between staff and patients.
- There were systems and processes to assess, plan and review staffing levels at the location, including staff skill mix.
- There were systems and processes to protect people from abuse and harm. Staff understood their responsibilities and the process to take in the event of any safeguarding concerns.
- The service gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff gave patients enough food and drink to meet their needs. Nutritional assessments were completed on admission.
- Staff monitored and assessed patients regularly to see if they were in pain.
- The service took account of patient's individual needs.

Nigel Acheson

Summary of findings

Deputy Chief Inspector of Hospitals
(London and South Regions)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long term conditions	Requires improvement 	Neuro-rehabilitation of adults with complex neurological disabilities with cognitive and behavioural impairment, were the main activity at the location. We rated this service as requires improvement in the safe, effective and well led domains. Good in caring and responsive.

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at
Long term conditions

Summary of this inspection

Background to The Raphael Hospital

The Raphael Hospital is operated by Raphael Medical Centre Limited (The). The hospital opened in 1983 and is a private hospital in Hildenborough, Kent. Referrals are accepted from across the south-east of England. The majority of the referrals are received from the clinical commissioning groups (CCG's) for NHS patients. The hospital also accepts private patients, funded by patients themselves or insurance companies.

The hospital specialises in the neurorehabilitation of adults following acquired brain injury. It provides a service for people over the age of 18 years, both male and female. The service does not treat children or young people.

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

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

The hospital has been registered since 1983. There is a Controlled Drugs Accountable Officer at the location.

The service employs 134 whole time equivalent clinical staff including doctors, nurses, therapists and rehabilitation assistances. The hospital also has a step-down facility. The step-down facility was not inspected on this occasion.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector with expertise in mental health, two inspection managers and a specialist advisor with expertise in neurorehabilitation. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about The Raphael Hospital

The hospital has four wards and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 act
- Diagnostic and screening procedures

During the inspection, we visited all areas of the service. We spoke with 19 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with nine patients.

During our inspection we reviewed 14 sets of patient records, including seven medicine charts.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

The service has been inspected four times, and the most recent inspection took place in February 2017.

Activity (January 2018 to December 2018)

- In the reporting period January 2018 to December 2018, the hospital received 63 referrals for admission. At the time of inspection there were 48 patients with a further ten in the stepdown accommodation (not inspected). The majority of patients (95%) were NHS funded.
- There were eight patients on the neurobehavioral rehabilitation ward (for patients with dual diagnosis and mental health issues, and for patients subject to

Summary of this inspection

section under the Mental Health Act), 31 patients in the main house acute neurorehabilitation wards (for patients with complex degenerative neurological conditions, slow stream neurorehabilitation and disorders of consciousness), and 21 in Tobias House (for patients with disorders of consciousness and slow stream rehabilitation).

- Three doctors worked under rules of practising privileges, one full time and two-part time. The hospital employed one doctor was full time. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. There were 18 nursing staff who worked full time. The hospital employed 17 therapists, 21 other allied health care professionals and 72 health care assistants. The hospital made use of both bank and agency staff when necessary.

Track record on safety

- No never events
- The service reported 254 incidents within the reporting period.
- Three incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- The hospital received 10 complaints between January 2018 and December 2018.

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 

Are services safe?

Our rating of safe stayed the same. We rated it as Requires improvement because:

- Infection control issues identified in the last report remained. Although there was a plan to make changes, the pace of making sure compliance with infection control regulations was slow.
- Systems and processes to protect patients against cross infection were not always effective. We found cleaning products and other liquids were not stored securely. Flooring and furniture in the special care unit was not fit for purpose.
- The service generally had suitable premises, but the design, maintenance and use of facilities and premises did not always keep people safe. For example, we found ligature risks in the special care unit which had not been risk assessed for five years, along with multiple hazards identified in garden.
- Staff and patients did not always have access to call-bells to get help. Communal areas such as the lounge, activity room and corridors did not have call points available
- Emergency buzzers were available, but staff we spoke to were unaware if these had been tested or whose responsibility this was.
- Staff on the special care unit were not able to communicate effectively, particularly in an emergency. two-way radios were available, but we found only two were working and of the two working radios, only one was able to make and receive calls.

However,

- There were systems and processes to assess, plan and review staffing levels at the location, including staff skill mix.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Risks to patients were assessed, monitored and managed on a day-to-day basis.

Summary of this inspection

Are services effective?

Requires improvement 

Are services effective?

Our rating of effective went down. We rated it as Requires improvement because:

- The service completed local audits but the results did not always drive the necessary improvements. For example, there was limited formal process to monitor staff adherence to national guidelines and local policies, such as hand hygiene, and ligature risks.
- Best interest meeting notes, were not consistently completed, and the least restrictive option was not always clearly identified.

However:

- Staff assessed the patient's physical, mental health and social needs holistically. Overall, staff provided care, treatment and support in line with evidence-based guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patient's dietary requirements, and used special feeding and hydration techniques when necessary.
- Patients' pain was assessed and managed appropriately.
- The service monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made efforts to ensure staff were competent for their roles. Overall 91.5% of staff had received an appraisal. All staff received a one-week induction.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had received care that met all their needs, including physical, emotional and social needs. Doctors, nurses and other health care professionals supported each other to provide care. Staff respected their colleagues' opinions.
- Services supported care to be delivered seven days a week.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Are services caring?

Good 

Are services caring?

Summary of this inspection

Our rating of caring stayed the same. We rated it as Good because:

- Staff cared for patients with compassion. Feedback from people who used the service, and those who are close to them was positive about the way staff treated people.
- Staff gave emotional support to patients to minimise distress. Staff were on hand to offer emotional support to patients and those close to them. Patients and relatives told us they felt able to approach staff if they felt they needed any aspect of support.
- Staff involved patients and those close to them in decisions about their care and treatment. We saw effective interactions between staff and patients. Staff kept patients and those close to them, informed and included them in their care and treatment decisions from pre-admission to discharge.
- The service used a goal setting approach to work in partnership with patients, supporting each patient individual decision-making process of their care and treatment.

Are services responsive?

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as Good because:

- The service planned and provided services in a way that met the needs of the local people.
- Services were planned to take into account the individual needs of patients. There were arrangements for patients with complex health and social care needs. Adjustments were made for patients living with a variety of disabilities.
- People could access the service when they needed it. Arrangements to admit, treat and discharge patients were people-centred and in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

Are services well-led?

Are services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as Requires improvement because:

- The service did not have managers at all levels with the necessary experience, knowledge and skills to lead effectively.

Summary of this inspection

The main house was managed by an experienced ward manager who had been in post since 2015. However, during inspection it was identified that three out of four of the wards did not have a ward manager.

- Managers could not demonstrate adequate systems and processes that assured us they had full oversight of the service in terms of risk, quality, safety, and performance.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care but there were some areas that were not fully effective. These included the arrangements for monitoring the progress of actions from internal audits, and oversight, management and reduction of risk to patient safety.
- The systems used to identify risks and eliminate them were not always carried out in a timely manager. Although there was a risk register, there was no robust way of ensuring effective risk reduction strategies had been undertaken, or risks not fully recognised.

However:

- Staff had effective working relationships with each other. There were clear staff support networks and all staff we spoke with felt supported by their colleagues.
- The service routinely collected, managed and used information to support its activities.
- The service encouraged patients and relatives to contribute to the running of the service, and give ideas for improvement, through regular meetings and feedback surveys.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Long term conditions

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

Are long term conditions safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, however not all staff were up to date with their training. The service did not set target for completion.

Staff received mandatory training in safety systems, processes, and practices. Mandatory training consisted of a range of topics, which included fire safety, infection control, moving and handling, stress management, health and safety, risk assessment and equality diversity. Staff received their mandatory training either face to face, attending an offsite course or via watching a DVD. The hospital had recently introduced an e-learning package for some of their mandatory training.

The service did not separate their mandatory training data by staff group. Mandatory training was broken down by departments. The service did not have a set target for completion of all mandatory training. However, the operations director told us the target was 100%.

Compliance with mandatory training was as follows:

- Control of substances hazardous to health 83%
- Fire safety 67%
- Infection control 84%
- De-escalation 54%
- Moving and handling 81%
- Health and safety 88%
- Risk assessment 75%
- Confidentiality and data protection 73%
- Food hygiene 69%
- Stress management 69%
- Basic life support and cardiopulmonary resuscitation 66%
- Equality and diversity 83%
- Deprivation of Liberty 81%
- Challenging behaviour 75%
- Safeguarding adults and children 67%

We saw compliance with mandatory training varied, and no departments or modules achieved the 100% compliance target. For example, from the figures provided, we saw the subjects with the best overall mandatory compliance rates was health and safety. The least overall compliance was de-escalation training. The operations director, told us they were aware of gaps in training, this was due to the movement to the new system. Training compliance was being closely monitored via appraisals and supervision meetings.

Following inspection, the provider told us they reviewed the method for calculating mandatory training, as at the time of the inspection and found inaccuracy.

They provided data, which indicated the actual compliance rate at the time of the inspection was 93% averaged for all mandatory courses.

- Manual Handling – 88%
- DoLS – 98%
- Safeguarding – 100%
- Mental Capacity Act – 100%
- Equality, Diversity & Inclusion – 70%
- Confidentiality/DPA – 81%
- Health and Safety – 100%
- Fire Safety – 100%
- Infection Control – 100%

The operations director and the human resources team were responsible for the oversight of mandatory training compliance. Staff we spoke with told us they felt their training was good.

Safeguarding

There were systems and processes to protect people from abuse and harm. Staff understood their responsibilities and the process to take in the event of any safeguarding concerns.

The service had an up to date safeguarding adult's policy for staff which was available to guide staff on how to protect people from abuse. This referred to relevant legislation and guidance. The policy included flow charts providing a quick reference guide to staff on what to do should a concern be identified. The safeguarding policy also contained sections on recognising and actions to take if domestic abuse, or female genital mutilation was found or suspected.

All staff we spoke to knew how to raise a safeguarding issue or concern. Staff confidently described what constituted abuse and described their own experiences of escalating safeguarding concerns to the nurse in charge. An electronic incident form was completed and the director of nursing or operational director were told. All staff said they were up to date with their training on safeguarding.

During our inspection we looked at three safeguarding records. We saw all referrals were made in line with the service's policy, and had been investigated and records of any actions taken to lessen the risk. We saw there were processes to inform the local safeguarding authority and the Care Quality Commission.

In addition, following a safeguarding referral staff completed a reflective account of what happened. Undertaking a reflective account following an incident is a way of studying your own experiences to improve the way you work, and help prevent a reoccurrence of an event or incident and aids learning. We looked at two reflective accounts during our inspection, and saw they showed staff considered how they could improve their practices. Managers used them as a way to clarify the staff members expectations and a way of giving feedback.

Staff could identify the safeguarding leads for the service, and could explain the actions they would take if they had any concerns. Named professionals have a key role in promoting good practice within their organisation, providing advice, and expertise for colleagues.

Safeguarding training level two was mandatory for all clinical staff, and was undertaken three times a year. Data indicated between January and December 2018, the overall compliance was 67%. The departments ranged between 75% for nursing staff in the special care unit, and 61% for nursing staff in the main house. Following inspection, the provider sent us data, which indicated the compliance rate for safeguarding training was 100%. In addition, the provider sent us data which indicated, 15 members of staff were required to complete level 4/5 safeguarding training and 91% had completed the training.

Cleanliness, infection control and hygiene

There were processes to protect patients against cross infection. However, these systems were not always effective. Infection control issues identified in the last report remained. Although there was a plan to make changes, the pace of making sure compliance with infection control regulations was slow. Equipment was visibly clean and staff had a good understanding of responsibilities in relation to cleaning.

The service had an up to date infection prevention and control policies for staff to follow. This included but was not limited to hand hygiene, waste management, and blood spillage. However, the policy lacked references, so it was unclear if the policy was in line with best practice.

Infection control training was mandatory for all staff groups, and was undertaken twice a year in June and

December. Data indicated for December 2018 training compliance rates ranged between 75% compliance for kitchen and maintenance staff and administration staff and 90% and 91% for nursing staff in Special Care Unit and domestic and laundry staff. The therapy departments were 89% compliant with this training and nursing staff in the main house were 82% compliant. We did not have infection control training compliance figures for medical staff. The service did not have target for compliance.

We saw personal protective equipment, and alcohol-based hand-sanitising gel was available throughout the location. However, in the special care unit we found alcohol-based hand-sanitising gel was freely available in the lounge area and in all the bedroom areas. The bottles were free standing, and could be thrown, or ingested by patients.

We looked at the dirty utility room at Tobias House, which had a separate dedicated hand wash basin. The dirty utility room was small and cluttered. Staff were unable to use the sink as multiple bags of linen blocked access to it. This meant staff were not able to clean their hands or remove their personal protective equipment correctly, and increased a risk of cross infection. The provider told us the sluice was inspected and cleared on an hourly basis.

The linen room at Tobias House was fully stocked and linen correctly stored. However, we found unused mattresses were stored in the linen room. We inspected the mattresses and found them to not be clean. We fed this back to staff at the time of inspection.

Staff could not always clean their hands in line with National Institute for Health and Care Excellence quality standard 61. Alcohol-based hand-sanitising gel, was available at the point of care, there were no dedicated hand wash basins in patients' bedrooms, staff and visitors used the basins in the bedrooms en-suite bathroom or the hand wash basins in the corridors. Quality standard 61 recommends hands can be cleaned using the alcohol-based hand sanitising gel except in the following situations, when soap and water must be used. When hands are visibly soiled or potentially contaminated with body fluids, or when caring for patients with vomiting or diarrhoeal illness, regardless if gloves have been worn.

The hospital corridors had carpet which could not be as easily cleaned as the laminated flooring when spills occurred. Department of Health's Hospital Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. We saw some of the carpet looked visibly clean, while other parts of the carpet were stained. We found this at our previous inspection in February 2017. The registered manager told us they were going to keep the carpet in the main corridor, and had just sourced the correct colour, which was due to be replaced.

There was a plan to make changes to the flooring in patient bedrooms, but the pace of making sure compliance with infection control regulations was slow. At the previous inspection in February 2017, we identified that patient's bedrooms and bathrooms had carpet. The registered manager told us they were changing the flooring in patients' bedrooms to a laminate type, but had only managed to change the flooring in seven bedrooms, due to occupancy levels.

The flooring in the special care unit was in a poor state of repair, and not clean. We saw the flooring was not intact, and was torn or had holes in place. The carpet and flooring, was stained and appeared to be visibly dirty.

In the special care unit, the kitchen area, used by staff and patients to prepare all meals, was untidy and was not visibly clean. There was no tile grouting in the area at the back of the kitchen sink and cupboards, which was extremely dirty with visible dirt and old food debris at the back of the sink unit, underneath the unit and in all cupboards. The kitchen table and work surfaces were heavily scratched and stained, again with visible dirt and old food debris across all the work surfaces.

The hospital did not recognise these issues as a risk and potentially placed patients at risk of cross infection. These issues were not included on the risk register.

There were processes to monitor and audit the cleanliness of the environment, but measures to rectify the non-compliances were ineffective. We saw cleaning audits were undertaken regularly. We looked at the cleaning audits for the ground floor (main house) and the special care unit.

We looked at the cleaning audits for ground floor (main house) for October, November and December 2018. Action plans were developed for any non-compliances

identified. This included the issue identified, action required and person responsible. However, we saw the same non-compliance was identified for three months and no corrective action had been taken.

Dedicated cleaning time was provided for the special care unit, however the poor state of repair impeded effective cleaning. Two bathrooms we looked at were visibly dirty with old stains on the toilets and floors. We asked staff to show us any environmental audits carried out and we were told there were none. We subsequently saw one audit of special care unit, dated September 2018 although it was not clear who had carried out the audit. The audit undertaken had no overall percentage of achievement calculated and there was no evidence of any further audits. In the September 2018 audit, we saw 20 areas out of 61 (33%) had fallen below the required standard and had failed. There was no evidence of any form of corrective actions relating to the areas that had fallen below the expected standard and in the undated special care unit local quality improvement plan the issues raised about poor cleanliness had been given a "closed" status. We had concerns about poor cleanliness at our previous inspection in 2017. Infection control risks were not recorded on the risk register.

Control of substances hazardous to health training was mandatory for staff and undertaken once a year. Data indicated for June 2018, an overall compliance rate of 83%. The departments ranged between 58% for administration staff and 91% for nursing staff in Tobias House. We saw 87% of staff working at the special care unit, were compliant with their COSHH training

Cleaning products and other liquids were not stored securely. We identified other concerns and unmitigated risks relating to the availability of liquids, on the special care unit. For example, plant feed liquid was on a window sill in the unlocked activity room. The cupboard under the kitchen sink was unlocked, despite staff saying it should be locked and it housed liquids such as washing up liquid and household cleaning fluid. In addition, we found the cleaning cupboard in Tobias to be unlocked.

As all patients were nursed in single rooms any patients with an infection were isolated. We spoke with staff who could tell us the infection control precautions they would use in the event of a patient developing an infection.

Waste was separated and in different coloured bags to signify the different categories of waste. In addition, we checked the outside waste compound and found it to locked. This was in accordance with the Health Technical Memorandum 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations.

Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of pseudomonas and Legionella bacteria. We saw the hydrotherapy pool was closed due to an abnormal result, and corrective action was being taken.

Between January and December 2018, there had been no cases of Clostridium difficile or Meticillin-sensitive Staphylococcus aureus (MSSA). There were three cases of Meticillin-resistant Staphylococcus aureus. MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. Clostridium difficile is a type of bacteria, which can infect the bowel and cause diarrhoea. We saw patients were screened for MRSA on initial admission to the hospital and re-admission after hospital stays.

Environment and equipment

The service generally had suitable premises, but the design, maintenance and use of facilities and premises did not always keep people safe. We found equipment well maintained, with a regular and up to date programme for servicing.

The main house had three floors, and had 22 en-suite bedrooms on the first floor, and eight on the second floor. On the ground floor there were the reception, a common lounge area, a dining room and kitchen. The physiotherapy gymnasium, hydrotherapy pool and three therapy rooms were also located on the ground floor.

Tobias House had 20 en-suite bedrooms, a gymnasium, therapy rooms for speech and language therapy or dietitian review, music therapy, and art therapy.

The special care unit, was for patients with dual diagnosis and mental health issues, both pre and post trauma. In addition, patients subject to detention under the Mental

Health Act were admitted to the unit. The unit was on one floor, and consisted of nine patient bedrooms, a nursing office, consulting room, kitchen/dining room and large therapy room.

We found the special care unit, presented challenges for clear observation of the patients and staff managed this through individual risk assessed observation levels. A staff member was always available in the communal lounge areas.

Ligature risks and lack of audit were not included on the risk register. This meant the service, did not recognise their issues as a risk to patient safety.

The special care unit provided a service for any patients experiencing poor mental health who may have had feelings of self-harm and/ or suicide. Staff were not able to describe where the high-risk ligature anchor points and ligatures were and how these risks were lessened and managed. We found there were many ligature risks throughout the special care unit and these included, bedroom curtains rails fixed to the wall, fixed wardrobe rails, hanging basket fixed to the wall fittings throughout all areas, including all bedrooms and bathrooms.

Staff said the last ligature risk assessment had been carried out over five years prior to our inspection and they were unable to locate this audit. A ligature point is a place to which patients' who are intent on self-harm might tie something too, to harm themselves. There was no clear guidance on the special care unit about how ligature risks were managed and how to report new risks. Staff could say they reduced risk by individually assessing patients and increasing their levels of staff observation if required. Staff said they were not aware the special care unit was undergoing any improvement schedule to up-grade the anti-ligature specification of the ward and patients' bedrooms and bathrooms.

Patients' rooms were made to look like a home environment rather than a clinical area. In each room there was an electric bed, chest of drawers, wardrobe. Not all bedroom doors had window recesses which meant staff could not see into the room if the door was closed. The ensuite facilities in the rooms either had bath, shower or were of a 'wet room' style, a toilet and hand wash basin. We saw that there were rails present to help patients with their stability.

We saw patients' rooms were bright and airy and made to look like a home environment rather than a clinical area and some reflected the resident's individuality. Windows looked onto gardens.

The garden in the special care unit was not a safe area and we found several unmitigated risks in the garden area which we raised with staff. The special care unit had a private garden area. Staff told us patients used the garden area on a regular basis and that weather permitting therapy groups took place in this area during the summer months.

However, the garden area was untidy, for example, we saw items of rubbish scattered around including an old telephone box, scaffolding poles, fence panels, a disused shed and uneven patio slabs. The garden fence, in some areas had barbed wire across the top which was within arm's length from the garden. Patients admitted to special care unit had complex diagnosis and presentations which included marked cognitive impairment and mental ill health. Patients could injure themselves either by accident or deliberately in the garden area.

The therapy gymnasium was well equipped with equipment that looked new and well maintained. Treatment couches in the physiotherapy department were covered with a wipeable fabric. The fabric on every piece of equipment we checked was intact.

Decoration was not in line with Health Building Note 00-09; Infection control in the built environment. Throughout the service walls were covered in a textured surface coating. The walls were not smooth and the coating had been applied in such a way as to be of a rough cast finish. This meant the cleaning of walls would be difficult.

On the special care unit, we found the fixtures and fitting were not maintained. For example, all the arm chairs in the lounge and activity room were heavily stained and ripped. We also saw walls were stained throughout. We asked staff to show us any environmental audits carried out relating to equipment, fixtures and fittings and were told there were none. We subsequently saw one audit of the special care unit, dated September 2018, although it was not clear who had carried out the audit. The audit undertaken had no overall percentage of achievement calculated and no evidence of any further audits taking

place. In the September 2018 audit, we saw five areas out of 19 (26%) had fallen below the standard and had failed. There was no evidence of any form of corrective actions relating to the areas that had fallen below the expected standard and in the undated special care unit local quality improvement plan the issues raised about poor environment and equipment had been given a "closed" status. We found the same concerns in our 2017 inspection.

We saw there was a rolling programme of planned preventative maintenance for equipment. Equipment was regularly serviced. The service records showed equipment had been serviced within the 12 months prior to inspection. We saw an electrical safety check certificate, dated December 2017. We saw ten pieces of equipment had safety checks completed within the last 12 months.

Staff told us there were no issues accessing equipment for patients, and felt they had enough equipment to run the service. We were told there were no issues around securing the necessary equipment for individual patients, which would be identified on pre-admission, and during regular assessments.

Assessing and responding to patient risk

Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenges. People were involved in managing risks and risk assessments were person-centred, proportionate and reviewed regularly.

The service had a clear process which set out safe and agreed criteria for the admission to the hospital. When referrals were made to the hospital an admission committee reviewed it, to assess for suitability for care and treatment provided. All patients were reviewed prior to admission and a detailed treatment plan decided.

Patients were assessed for risk through a set of risk assessments on admission to the service. These included risk assessments for falls, malnutrition, pressure ulcers, and risk of developing a blood clot. All risk assessments were completed and reviewed regularly. For example, all patients were risk assessed on admission for their risk of developing a type of blood clot called, venous thromboembolism (VTE). This was in line with the National Institute for Health and Care Excellence (NICE), quality standard three, statement one.

We reviewed 10 sets of patient records and saw risk assessments were documented for each patient and stored within the notes, or on their electronic record. Each patient had a range of risk assessments undertaken on admission. These included the risk of falls, nutrition status, skin integrity and pain. We saw the risk assessment documents were continuously reviewed, and risk lessening strategies or medical interventions started if needed.

All patients received a range of multi-disciplinary assessments which included assessments by doctors (physical and psychiatry), physiotherapy, neuropsychology, occupational therapy, speech and language therapy, art therapy, music therapy, eurythmy (expression of movement art), drama and neuro functional reorganisation. All the assessments identified risks and care plans were generated on how risks would be mitigated and reduced.

Patients in the special care unit had additional checks to ensure their safety and reduce any identified risks. For example, patients had checks on their whereabouts, food and fluid intake, records, on personal care delivery and any challenging behaviour.

Patients were monitored for the risk of deterioration and patients received an early medical intervention to improve their clinical condition in the event of deterioration, in line with National Institute for Health and Care Excellence (NICE), guideline (NG), 51, sepsis: recognition, diagnosis and management. The service used the National Early Warning System (NEWS) track and trigger flow charts. National Early Warning System is a simple scoring system of physiological measurements (for example, blood pressure, temperature and pulse) for patient monitoring. This allowed staff to identify patients who were becoming unwell, before they became critical, and provide them with increased support. We looked at eight sets of national early warning system charts, and saw they were completed fully, and scored correctly. We saw the escalation process was followed for patients

whose observations showed they be experiencing a deterioration in their clinical health. Staff on the wards told us that in the case of a deteriorating patient there was never any difficulty in accessing medical support.

The hospital did not have facilities for an acutely ill patient and they were transferred to a local NHS trust. Staff could give us examples of when this had occurred and how the situation had been managed. Basic life support (BLS) and cardiopulmonary resuscitation (CPR) training were mandatory for all staff and undertaken twice a year. Data showed for December 2018, an overall compliance rate of 66%. The departments ranged from 46% compliance for nursing staff in Tobias House and 82% for all therapy departments. The operations manager told us they were aware of the gaps in training and the compliance rates were being closely monitored via appraisals and supervision meetings.

The hospital undertook regular safety checks on patients. The checks were a structured process, called 'intentional rounding' where nurses carried out regular checks with individual patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

Emergency buzzers were available, including in the therapy rooms and the physiotherapy gymnasium, and patients carried their own personal emergency alarms. Staff we spoke to were unaware if these had been tested or whose responsibility this was.

Staff on the special care unit were not able to communicate effectively, particularly in an emergency. Staff on the special care unit, did not carry individual alarms. As a risk reduction strategy, staff had been issued with two-way radios to communicate with one another. However, staff told us all but two radios were not working and of the two working radios, only one was able to make and receive calls. When staff were asked what happened in an emergency they said all they could do was, "shout". The layout of the special care unit meant there were areas of the unit where shouting would not be heard. This put staff and patients at risk in making sure a prompt and timely response by staff in an emergency. In addition, there was no method of summoning emergency assistance from the rest of the hospital, other than via telephone. Staff not being able to communicate effectively in the event of an emergency, was not included on the risk register.

Staff and patients did not always have access to call-bells to get help. Patient bedrooms had a nurse call bell system for patients to use but there were rooms, such as the staff office and all communal areas such as the lounge, activity room and corridors which did not have call points.

Some patients had 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions made in their notes. The DNACPR was recorded electronically in the electronic system, and a paper version was kept in the patient's medical file. We saw the DNACPR status was recorded on the nurse handover sheets.

Nurse staffing

There were systems and processes to assess, plan and review staffing levels at the location, including staff skill mix.

Staff were from various professional backgrounds, including medical, nursing (psychiatric, general, learning disability) psychology, occupational therapy, speech and language therapy, and social work and activity specialists.

There were systems and processes to assess, plan and review staffing levels on the wards, including staff skill mix. Staffing levels adhered to national guidance recommendations, such as the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long Term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.

The service employed 18 whole time equivalent (WTE) registered nursing staff and 72 whole time equivalent health care assistants.

Rotas were planned, which allowed for adjustments to be made to make ensure the correct skill mix to provide safe patient care. Shortfalls in the staffing levels were covered by either bank staff or agency staff.

Information provided by the hospital showed in the three months prior to inspection two shifts were covered by registered nurses and three by health care assistants as bank staff. During the same period, 123 shifts were covered by registered nursing and 181 by health care

assistants as agency staff. At the time of inspection there were 10 registered nursing (eight general nurses and two mental health nurses), and seven health care assistant vacancies.

One of the vacancies was for a ward manager on the special care unit, who had left the hospital ten months prior to inspection. Staff told they felt this had led to a lack of clear leadership.

The average sickness rate for the three months prior to inspection was 27% for registered nurses and 17% for health care assistants.

Allied Health Care Staffing

The service had enough allied health care staff to keep people to keep patients safe and provide the right care and treatment.

The hospital had a large therapy team which included physiotherapists, occupational therapists, psychologists, speech and language therapists, art therapists, music therapists, drama therapist, eurhythmy and external application therapists. Therapist staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long Term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.

The service employed 16 whole time equivalent (WTE) and one-part time therapists and 21 whole time equivalent and two-part time, other allied health care professionals.

Information provided by the hospital showed in the last three months prior to inspection, no shifts were covered by bank or agency for this staffing group. At the time of inspection there was one therapist and two other allied health professional vacancy.

The average sickness rate for the three months prior to inspection was 25% for therapists and 20% for other allied health care professional.

Medical staffing

The service had enough medical staff to keep people to keep patients safe and provide the right care and treatment.

Medical staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BSRM), the National Service Frameworks for Long Term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury, and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness.

All patients were under the care of a consultant for their relevant conditions. There were consultants available across the wider hospital who specialised in psychiatry, rehabilitation medicine and neuropsychiatry. Staff said they had timely access to doctors.

The hospital directly employed one doctor full time and three doctors under practising privileges (one full time and two-part time). Information provided by the hospital showed that no shifts had been covered by an agency doctor.

Medical staff had a low sickness rate during the reporting period, which was 0%.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to date and available to all staff providing care. We looked at 10 patient records and found they contained patient reviews, and clear treatment plans. All entries of patient admission were signed and dated. There was clear recording from therapy staff. We found up to date and completed risk assessments and saw they were reviewed regularly.

Records were both paper based and electronic. Electronic care plan records had been trialled at Tobias House, and were due to be rolled out across the whole service. We looked at five paper based records and five electronic records. All records both paper and electronic were stored securely when not in use, in line with the Data Protection Act 1988.

The electronic patient records were only accessible through password protected systems to authorised staff. Staff could view and share patient information to deliver safe care and treatment in a timely and accessible way.

The paper-based records we looked at were generally found to be accurate and fit for purpose. We saw they were stored securely when not in use. Most entries were signed and dated, and easy to follow. However, medical staff did not always print their name or time their entries. Medical, therapy and nursing staff wrote in patients' medical notes. This is in line with National Institute for Health and Care Excellence (NICE), quality standard (QS) 15, statement 12, patient experience in adult services, which says health and social care professionals should ensure they support coordinated care through clear and accurate information exchange.

Nursing risk assessments and care records, such as observations charts, and fluid balance charts, were placed in a folder at the end of the patient's bed, along with the patient's medication chart.

Care plans were personalised, holistic and recovery focused. We found they were completed in a timely manner and regularly reviewed. The care plans, charts, daily progress notes and three-monthly evaluations were of a very good standard and covered all aspects of physical, mental health and social needs. There was a care plan summary available for each patient which could, in addition to providing information for staff, be printed off and accompany the patient to any hospital appointments. Each patient had a full care plan review at least every three months and all patients and their relatives were invited to participate. Care plan topics included: physical health care, recovery and lifestyle, capacity, communication, moving and handling, eating and drinking, medicine, mental state and behaviour, mobility, keeping active, personal hygiene and preferred day time routines. Information in the care records included patient bibliographies, previous employment, key family history, likes, dislikes, preferences and advanced directives should the patients' health deteriorate. All staff we spoke with said their patients, "received effective care" and that "we are here to provide effective and person-centred care, our patients are the priority here".

Physical health care plans were completed to a good standard with information about referrals and assessments by the wider multi-disciplinary team. For example, with one patient there was clear guidance for staff on safely managing dysphagia and associated risk of choking, management of epilepsy and organic brain damage with unsteady gait. In another example there was clear and concise guidance on brain degenerative disease and associated psychosis. We saw the family were involved in the care planning process.

Charts for checking where patients were, and food and fluid intake were well maintained. All patients had these assessed and recorded. Targets were clearly identified and actions to be taken detailed should targets not be made.

Medicines

Staff gave, and recorded medicines well. Patient's received the right medication and the right dose at the right time. Fridge and room temperatures were recorded.

This service had systems to ensure the safe supply, administration and disposal of medicines.

Staff stored medicines securely. We saw medicines were stored securely and handled safely. We saw medicines were stored in locked cupboards which were accessed via a key which only registered nurses held. There were systems to check for out of date medicines. Staff told us a member of staff checked the medicines to make sure they were all in date. During the inspection we randomly checked medicines and found them to be in date

We saw there were specific blue medicines disposal bins for staff to use to dispose of unused, expired or medicines that were no longer needed. This is in line with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.

Controlled drugs, such as morphine, are a group of medicines liable for misuse that require special management. All controlled drugs were kept securely in suitable locked cupboards, which were bolted to the wall and access to them was restricted. We saw the controlled drug register was completed, had the correct balance recorded and dated with two staff signatures.

The service had a controlled drug accountable officer (CDAO). The controlled drugs accountable officer was responsible for establishing, operating and reviewing appropriate arrangements for safe management of and

use of controlled drugs. Controlled drugs audits were undertaken every three months. We looked at the controlled drugs audits for September 2018 and November 2018. We saw staff were 100% compliant.

Medicines were stored within the recommended temperature ranges to maintain their function and safety. Appropriate medicines were stored in dedicated medicine fridges and records showed daily temperature checks were undertaken. We also checked the records for the ambient temperatures of the treatment room where medicines were stored which showed these had been completed correctly.

We reviewed prescription charts for five patients. These were signed and dated by the prescriber. Charts documented patients' allergies. There were no omissions of medicines on the patients' prescription charts. Consultants reviewed patients' medicines regularly.

There were processes for the stewardship of antimicrobials (drugs used to treat infections due to bacteria, viruses or fungi). We looked at five drug charts of patients who had been prescribed antimicrobial treatment. All prescriptions were signed and dated, and allergies were recorded. We saw all five had the dose and duration documented. This is in line with National Institute for Health and Care Excellence (NICE) quality standard (QS), 121, statement 3, recording information. However, only three out of the five reviewed had the clinical indication recorded, this is not in line with quality standard 121, statement 3.

The hospital had a service level agreement pharmacy to supply medications to the hospital. The hospital employed a pharmacist, who visited the wards regularly. The pharmacist audited and advised to ensure medications were clinically appropriate and to optimise outcomes. We looked at the agreement and saw it was signed and dated by the provider. However, the copy we looked at was not signed by the pharmacy provider.

Incidents

There were effective systems to report incidents. Incidents were monitored and reviewed and staff gave examples of learning as a result. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation.

The hospital had a process for categorising and handling incidents, including and up to date 'Accident and Incident reporting policy' version 4.2 (dated January 2017).

The service had not reported any never events in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between January and December 2018, the service did not report any serious untoward incidents. Serious incidents are incidents where on or more patients, staff members, visitors or members of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.

The service reported 254 incidents within the reporting period. Most incidents reported were behavioural incidents (148), followed by other (24), equipment failure (16) and falls (14). The least related to incidents of abuse (1) or suicide or attempted suicide (1), care practice (2), patients fainting (2) self-harm (3), and medication errors (3). The incident reporting rate was variable throughout the year.

All senior members of the management team were aware of any issues or concerns. The management team investigated the incidents to establish the cause. New incidents were discussed at the newly implemented daily meetings.

An electronic based system was used to report incidents. Staff were aware of the system and knew how to use. Staff told us they received feedback from incidents at team meetings.

Staff were encouraged to report incidents and they were confident about reporting issues. They were aware of the type of incidents they needed to escalate and report. Staff told us they made time to report incidents

Patient specific issues were communicated via care plans and individual support guidelines. Senior clinicians provided patient specific training for staff where the clinical team assessed the treatment plan needed additional support and guidance, for example, education on epilepsy and seizures. We looked at the four most recent incidents on special care unit, in addition to two

incidents of restraint and saw staff had discussed the incidents and reviewed patient risk assessments and care plans accordingly. For example, successful interactions and communications were reviewed by the team to encourage a patient who had been refusing to carry out their personal care.

Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened.

Mortality and morbidity incidents were discussed as part of the Medical Advisory Committee (MAC) meetings which met every four months.

Safety Thermometer (or equivalent)

The service formally collected safety performance data. However, we did not see safety performance data collected was discussed in meetings. Safety performance data was not on display to keep patients and visitors informed about the ward performance.

Medical records showed patients were assessed for their risk of venous thromboembolism (VTE). This was in line with National Institute for Health and Care Excellence (NICE) Quality standard three, statement one. Between January and December 2018, there had been no incidences of hospital-acquired venous thromboembolism.

Risk assessments for pressure ulcers and falls were part of the nursing assessment documentation and we saw these were up to date, completed and regularly reviewed. We saw actions were appropriately followed up, such as use of a pressure care relieving mattress in records which identified patients at risk of developing pressure ulcers.

Between January and December 2018, there had been five cases of pressure ulcers at the hospital. Two were acquired at the hospital and three related to patients who had pressure ulcers present on admission.

Between January and December 2018 there had been 27 incidents of urinary tract infections, which was an improvement since our previous inspection. At our previous inspection the service told us they had recently introduced a process to reduce the number of urinary tract infections (UTI's). The process involved all patients had their urine tested weekly, according to the urinary tract infection protocol and care pathway. We saw ten records during our inspection which showed the weekly testing of urine was completed.

Safety performance data was not effectively communicated or used to drive improvement. Safety performance data was not displayed to keep patients, relatives and visitors informed. In meeting minutes we looked at, we did not see any safety data that was collected was discussed to see how data was used to drive improvements to the service or patient care.

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

Requires improvement

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

Evidence-based care and treatment

Staff assessed the patient's physical, mental health and social needs holistically. Overall, staff provided care, treatment and support in line with evidence-based guidance. However, we found there was limited formal process to monitor staff adherence to national guidelines and local policies, such as hand hygiene, and ligature risks.

The service commissioned external reviews from the ISO (International Organisation for Standardisation), to make sure aspects of its service met defined criteria. The hospital had been subject to external review in the last 12 months for ISO 9001 Quality Management Systems, ISO 14001 Environment Management Systems, ISO 18001 and ISO 45001 Occupational Health and Safety Systems, and ISO 22000 Food Safety Management.

The provider reviewed the service it provided in line with British Society of Rehabilitation Medicine (BSRM) Guidelines, National Service Framework for Long Term

Conditions, The Royal College of Physician Guidelines for Acquired Brain Injury and Prolonged Disorders of Consciousness (PDOC). We saw in the clinical governance committee, there was a dedicated section on the agenda for this.

Patients were assessed using recognised risk assessment tools to holistically assess patients physical, mental health and social needs. For example, the risk of developing pressure damage was assessed using a nationally recognised practice tool. Staff undertook falls risk assessments, nutrition status, and skin integrity

We saw the hospital had developed their service for patients who were in altered states of consciousness in line with the Royal College of Physicians Guidelines for people with prolonged disorders of consciousness (PDOC). They utilised the recommended structured assessment tools to aid accurate diagnosis and to monitor patients. For example, they used the Wessex Head Injury Matrix (WHIM) and the JFK Coma Recovery Scale. The provider ensured all patients were provided with appropriate diagnosis and we were told they would seek further opinions if required.

There was limited formal process followed to monitor staff adherence to national guidelines and local policies, such as hand hygiene, and ligature risks. For example, there were regular audits to monitor the environment and cleaning, we looked at multiple audits and found despite there being an action plan, we saw the same non-compliance was identified for multiple audits and no corrective action had been taken.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff completed a nutritional risk assessment when patients were admitted to the hospital. This is in line with National Institute for Health and Care Excellence, quality standard 24, statement one: screening for the risk of malnutrition. The risk assessment included a malnutrition universal screening tool (MUST) used throughout the United Kingdom, to assess people for risk of malnutrition. We looked at 10 during our inspection and saw they were fully completed.

Dietitians were available to support patients with nutritional advice. Speech and language therapists (SALT), were available if a patient needed help with swallowing.

The service supported patients with special dietary requirements, such as diabetes, lactose intolerance or soft/pureed diet.

The hospital used special feeding and hydration techniques when necessary. Staff explained that dietitians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously by-passing the usual process of eating and digestion. We looked at the records of four patients who were receiving parental feeding. We saw all patients had an up to date feeding regime, which had been regularly reviewed. We did not speak to any dietitians during our inspection, but staff told us they were accessible.

The chefs worked with the dietitian and speech and language therapist team to provide suitable menus in keeping with agreed standards.

We observed staff supported patients to eat independently and placed drinks within their reach.

Food hygiene training was mandatory for all staff and undertaken once a year. Data showed an overall compliance rate of 69% for June 2018. The departments ranged between 43% for nursing staff in the main house and 90% for domestic and laundry staff. Eighty-five percent of nursing staff in Tobias House had completed this training and 61% of nursing staff working in special care unit. Only 50% of kitchen and maintenance staff were compliant.

Food was transported from the kitchen in the main house to Tobias House via a plastic box on a trolley. We saw that food was put onto plates, and covered, this was then wrapped. The food was then placed into a plastic container on a trolley for transfer. Once the food arrived at Tobias House it was then given to patients. We did not see that there were any checks to make sure the food remained hot, or at a reasonable temperature for patients to eat. This meant, patients may not always receive food at a reasonable temperature.

Pain relief

Long term conditions

Patients' pain was assessed and managed appropriately.

The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) which states all in-patients with acute pain must have regular pain assessments using consistent and validated tools, with results recorded with other vital signs

We saw staff completed pain assessment tools for patients on the vital signs chart in eight of the ten records we reviewed. Staff used a non-verbal pain assessment to establish individual pain needs when a patient was not able to communicate verbally. This included by interpreting body language and facial expression. We saw that staff asked patients about pain, and documented the action they had taken.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them.

The service participated in national audits, including those outlined by the United Kingdom Specialist Rehabilitation Outcomes Collaborative. Where possible the results were used to benchmark and compare with other similar services nationally. In addition, patients are assessed against a range of criteria, initially at the point of admission, to decide their level of independence and further needs, and routinely throughout their stay. These assessments supported patients and their families to see the individual's progress.

The hospital took part in the United Kingdom Specialist Rehabilitation Outcomes Collaborative (UKROC) developed a national database collating all specialist neuro-rehabilitation services (level 1 and 2) across the UK. It provided information on rehabilitation requirements, the inputs provided to meet them, outcomes and cost benefits of rehabilitation for patients with different levels of needs.

The hospital used the Function Independence Measure (FIM) and the Function Assessment Measure (FAM) in auditing function changes. The functional independence measure is a global measure of disability and can be scored alone or with the functional assessment measure. We saw there had been a 32% improvement in their scores, from the previous year.

All patients were assessed using the 'health of the nation outcome scales' (HoNOS). These covered twelve health and social domains and allowed clinicians to build up a picture over time of their patients' responses to interventions. Staff told us how effective the treatment and therapy programme was, one said, "We had a patient admitted who could not walk and it was so rewarding to see how the therapy and treatment enabled the patient to walk and return home".

Other assessments used to measure patient outcomes included range of motion assessments, the JFK coma recovery scale and the scale for the assessment and rating of ataxia (SARA).

The hospital used the Northwick Park Therapy Dependency assessment (NPTDA) tool provided an assessment of therapy dependency. It is a measure of therapy intervention used in specialist neuro-rehabilitation settings, where rehabilitation is provided by a multidisciplinary team. The NPTDA included 30 items of therapy dependency in seven domains; physical handling programme, basic function, activities of daily living, cognitive/psychosocial/family support, discharge planning, indirect interventions and additional activities, specialist facilities, and investigations and procedures. The hospital had a 40% improvement their Northwick Park Therapy Dependency assessment scores.

The therapy teams audited patient outcomes by using a goal setting approach to each patient's rehabilitation. We saw every patient had an individual goals action plan in his or her medical notes. The multidisciplinary team discussed and reviewed these goals at internal team meetings.

Competent staff

The service made efforts to ensure staff were competent for their roles. Overall 91.5% of staff had received an appraisal. All staff received a one-week induction which included the completion of a booklet.

Staff training and professional development needs were identified through informal one to one meetings with their managers and annual appraisals. During the inspection we looked at five appraisals. We saw the

annual appraisals gave an opportunity for staff and managers to meet, review performance and development opportunities which promoted competence, well-being, and capability**.**

Data provided to us showed that overall 91.5% of staff had received an appraisal within the last 12 months. One-hundred percent of doctors, therapists and other allied health professionals had up to date appraisals. However, only 81.2% of nursing staff and 76.3% healthcare assistants had, had an appraisal within the last 12 months. Lack of appraisals may have meant the service did not address any potential staff performance issues.

Staff who had, had an appraisal told us they were undertaken yearly. They felt it was useful and managers discussed performance and opportunities for training and progression. We saw the system was used when poor or variable staff performance was identified. However, we found limited evidence that staff were supported to improve.

We reviewed five staff personnel records. All contained records of interviews, references, identification checks, contracts of employment and enhanced disclosure and barring service checks, and were completed within the last three years.

All new staff completed an induction programme ensuring new staff had all the information and competencies they needed to do their jobs. Staff told us the comprehensive programme included department tours, introduction to colleagues and completion of an induction booklet. During our inspection, we looked at five induction booklets and saw they were either completed or in the process of completion.

There were good opportunities for development and training for nursing, rehabilitation support assistants and allied professional staff. They were encouraged and supported to develop their expertise and competencies and extend their skills.

In discussion with staff they appeared very knowledgeable and confident in their roles. All the staff we spoke to commented on how much training they received. All staff received an induction period, completed mandatory training which included training on basic life support, first aid, mental health awareness, care planning, risk assessing and safeguarding. The provider had organised for a tutor to attend the hospital weekly to teach English for those staff who did not have English as a first language.

Applications for practising privileges from consultants were reviewed and granted or declined by the Medical Advisory Committee (MAC). This involved checking their suitability to work at the hospital, checks on their qualification, references, immunisation, and indemnity insurance. The hospital only granted practising privileges for procedures or techniques that were part of the consultant's normal practice.

At the time of inspection, there were two-part time and one full time consultants employed under practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. We looked at two practicing privileges folders, both contained references, General Medical Council (GMC) registration, indemnity insurance, up to date appraisal, identification, disclosure and barring service checks, and records of mandatory training compliance.

Multidisciplinary working

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients received care that met all their needs, including physical, emotional and social needs. Doctors, nurses and other health care professionals supported each other to provide care. Staff respected their colleague's opinions.

Patients had access to a variety of psychological therapies. Psychologists, occupational therapists and activity therapists were part of the multidisciplinary teams and were actively involved. Patients had access to a range of therapies such as cognitive behaviour therapy, occupational therapy, drama and movement therapy, music therapy and art therapy. There was evidence of detailed psychological assessments and assessments of neuropsychological functioning in patients records and care plans.

Requires improvement

Long term conditions

There was very good multidisciplinary team working; all staff disciplines had input into the planning, assessing and delivering of patients' care and treatment. The patients' holistic needs were assessed and therapies or treatments were tailored to their requirements.

Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the service. We observed good communication amongst all members of the staff. They reported that they worked well as a team.

Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another. Staff worked hard as a team to ensure patient care was safe. Staff told us the consultants and management team were approachable and they felt comfortable asking them questions and raising concerns with them.

The hospital used integrated patient records, which were shared by clinical staff and therapists. This improved communication and provision of care was better co-ordinated between healthcare professionals.

Staff told us they had access to a dietitian sometimes who attended regularly to assess and manage the nutritional needs of patients. We saw dietitians contributed to the patient's care plan and recorded instructions for other members of the multidisciplinary team.

Regular multidisciplinary meetings were held to discuss patients and their ongoing needs. This meeting was attended by therapist, nurses, doctors and patients' relatives or cares, and whoever commissioned the services.

Seven-day services

Services were made available that supported care to be delivered seven days a week.

There was not a responsible consultant available on site at all times, however arrangements existed to manage this. Consultants provided a 24 hour on call service. In-house physicians delivered the day to day medical service, who dealt with any routine and emergency in consultation with the relevant consultant assigned to the patient.

Between the hours of 6pm and 10am medical cover was provided by telephone. Staff told us they had never had any issues contacting the doctor out of hours. Staff told us in an emergency they would call 999 and the patient would be transferred to the local NHS acute hospital via an ambulance.

Rehabilitation continued seven days a week. Patients had access to therapy service seven days a week 9am to 8pm.

Health promotion

We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The Mental Capacity Act 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

There was a consent policy which staff adhered to. The policy was in date and provided information on gaining, and recording consent for provision of care and treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Deprivation of liberty training, was mandatory for all staff, and undertaken once a year. Data indicated for June 2018, an overall compliance rate of 81%. The departments ranged from 67% for domestic and laundry staff to 90% for nursing staff on the special care unit. We did not have deprivation of liberty training figures for medical staff. The service did not have a target for compliance.

Requires improvement

Long term conditions

Staff received training on the Mental Health Act as part of their induction training. We looked at the Mental Health Act documentation for one patient and all was in good order. Staff documented in the patients notes that rights had been explained to the patient as required by section 132 of the Mental Health Act.

Data provided to us showed that five patients had a mental health disorder and were in receipt of a formal care plan under the Care Programme Approach. Five patients who had their liberty, rights and choices affected, were supported by care plans. Twenty-four were subject to an authorisation under the Deprivation of Liberty Safeguards (DoLS). The provider had informed the CQC of all DoLS statutory notifications as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of inspection, three patients had a deputy appointed by the Court of Protection with powers to take decisions about the service provided. No patients were subject to an order by the Court of Protection that resulted in the restricting their liberty, rights and choices.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When a patient lacked capacity, staff made decisions in their best interests. Staff also considered and documented the patients' capacity to consent to care plans.

A standard template was used for the assessment of capacity. This made sure the requirements of the Mental Health Act were met. We looked at three mental capacity assessments and saw evidence of best interest decisions being made and documentation regarding conversations about a patient's care with the patient's family. We also saw this reflected in care plans and additional assessments for specific interventions such as medical procedures and personal care delivery. Documentation was available around best interest decisions in patients' notes and staff told us confidently what this meant.

Best interest meeting notes, were not written in a constant format, and the least restrictive option was not always clearly identified. We reviewed four best interest meeting records.

Are long term conditions caring?

Good

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

Compassionate care

Patients were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who are close to them was positive about the way staff treated people.

Patients were treated with dignity and respect. All staff we spoke with were passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible. Relatives we spoke with told us staff were caring, attentive and professional. A patient told us "The staff are very kind here, lovely". Another said, "Staff really care for us here".

We saw and heard staff delivering kind and compassionate care, going beyond the requirement and helped patients feel at ease. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence Quality Standard 15, statement one.

Staff respected patients' privacy and dignity. For example, we saw care interventions were carried out behind closed doors. We observed staff placed signs on doors 'do not disturb, personal hygiene in progress'. We saw how staff spoke to patients with respect and gave time for them to respond. Staff showed an understanding and a non-judgemental attitude when talking with patients.

Where possible staff made the service feel as normal as possible, for example, patients were encouraged to eat meals in the dining room, and wear their own clothes. Staff encouraged independence, for example, we heard staff offering and encouraging patients to make their own choices which included examples such as, "When would you like to go out on leave today? would you like to make your own drink? When would you like me to help you with your laundry? Do you want to try to do this yourself?"

On the special care unit, despite the complex needs of patients using the service, the atmosphere was calm and relaxed. We saw many swift interactions where staff saw

that patients were becoming agitated, distressed or overly stimulated, particularly with visitors on the ward. Staff immediately attended to their patients in a kind and gentle manner.

Emotional support

Staff provided emotional support to patients, relatives, and carers to minimise their distress.

Staff were on hand to offer emotional support to patients and were very happy to offer a listening ear. Both patients and relatives told us they felt able to approach staff if they felt they needed any aspect of support.

Staff told us they helped patients or their relatives, who became distressed in an open environment. They maintained their privacy and dignity by taking them to a private room where they could voice their concerns and worries. Staff told us they offered as much support as they could by listening to their patient's or relatives worries or concerns.

We found good examples of mental well-being care plans. If a patient should become distressed or anxious, guidance was given to staff about how they should respond and what interventions they could use. Care plans detailed positive behaviour plans and how a patient's independence could be supported safely.

All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. This information was very detailed and was summarised in the patients' individual care plans. For example, we spoke to staff who were able to confidently discuss their approach to patients and the model of care practiced. They spoke about enabling patients to take as much responsibility as possible for their care pathways. We saw evidence of patient involvement in the care records we looked at, particularly captured in the individual care plans. This approach was person centred, individualised and recovery orientated. We also saw that all patients reviewed their care plan once every three months with the multi-disciplinary care team and in regular meetings with a member of the ward nursing team. This is in line with National Institute for Health and Care Excellence (NICE) quality standard 15, statement nine: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff communicated well with patients and those close to them in a manner so they could understand their care, treatment and condition. Staff responded positively to questions and took time to explain things in a way, patients and their relatives could understand. This is in line with National Institute of Health and Care Excellence quality standard 15, statement two.

The patients and relatives we spoke with told us they found all members of staff respectful, responsive and approachable. They reported staff of all levels listened to what they had to say, acted upon their concerns and addressed any issues.

We saw effective interactions between staff and patients. Patients and those close to them were kept informed and included in their care and treatment decisions, throughout the process from pre-admission to discharge. The service used a goal setting approach to work partnership with patients, supporting each patient individual decision-making process of their care and treatment. This is in line with National Institute of Health and Care Excellence, quality standard 15, statement four.

Staff had accessible ways to communicate with people when their protected equality or other characteristics make this necessary. Information about care and treatment was provided in appropriate ways that patients were supported to understand the benefits and possible complications of treatment. This is in line with National Institute of Health and Care Excellence, quality standard 15, statement five.

Are long term conditions responsive to people's needs?

(for example, to feedback?)

Good

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

Service delivery to meet the needs of local people

Requires improvement

Long term conditions

The service planned and provided services in a way that met the needs of the local people.

The service mainly treated NHS patients, but also treated those who were either privately funded, or funded through insurance companies. At the time of inspection there were 59 NHS funded patients and one privately funded.

The service worked closely with the relevant commissioning services. There were regular meetings to make sure the service can respond to the needs of the local people. The service produced a pre-admission report to whoever commissions the service, this is reviewed and funding agreed before the patient moves to the service.

The grounds of the hospital were accessible to patients and their family and friends. Family and friends who wanted a private space were able to use the sitting rooms in the main building. However, the hospital did not have a designated area or the facilities for friends and family of patients to stay at the hospital. We were told if a flat was available in the step-down facilities this was offered for a limited time and in an emergency.

Meeting people's individual needs

Services were planned to take into account the individual needs of patients. There were arrangements for patients with complex health and social care needs. Adjustments were made for patients living with a variety of disabilities.

Care and treatment was tailored to meet the needs of the individual patients. All patients were risk assessed prior to admission to ensure the unit provided a safe environment. This allowed the service to make sure they had all the equipment necessary and could provide the appropriate therapy.

Patients ability to undertake activities of daily living (for example, help with walking, dressing, using the toilet or using the stairs) was measured using the Barthel scale. These assessment measures allowed staff to provide each patient with the right amount of support and supervision to keep them safe while in hospital.

The service was accessible by patients with a physical disability, or who used a wheelchair. We saw there were ramps to ease access to and from areas, doors were wide and bathrooms which had easy access showers, with no steps, and had handrails to provide extra support and stability when showering. There were good supplies of mobility aids and hoists to help staff care for patients. All patients were assessed prior to admission for their individual needs, and any specific equipment needed was ordered and available on admission.

There was strong individual patient needs assessment and care planning. We saw there were records of personalised assessment and care plans, where patients had given details about their preferences, likes and dislikes. Staff used information to tailor care, treatment and therapies for individual patients. For example, staff told us of a patient who had limited communication skills when they first arrived at the hospital. By identifying their likes and dislikes they were able to create a therapy programme that was unique to them. Staff told us as a result of this programme, the patient had started to respond and was able to communicate.

There were processes in place to help staff communicate with patients. Staff had accessible ways to communicate with people when their protected equality or other characteristics make this necessary. For example, patients who were unable to communicate verbally used non-verbal communication charts. We saw patient's individual communication needs were documented in their care plans.

Therapy was tailored to the individual needs of the patient. We saw all patients had their own weekly plan, which included a variety of therapies, such as art, music and relaxing therapies. Each patient had a board in their bedrooms displaying their schedule for the week. The schedule was updated weekly and was based on each patient's needs and objectives.

Care pathways were designed to be flexible to make sure different services worked together to meet the patient's changing needs. The hospital held regular multidisciplinary meetings, where goals and outcomes are discussed with the team, patients and their families, to discuss the patients ongoing needs.

We saw there was a choice of food options for patients. We spoke with the chef who told us they could make sure

patient preferences, religious or cultural needs, such as vegetarian, vegan or kosher meals. This was in line with the National Institute for Health and Care Excellence quality standard 15, statement 10.

The service provided three meals a day for patients, on a programme. Choices could be seen on menus and the staff spoke with patients daily to discuss any individual needs. The service could cater for any special dietary requirements such as allergies and intolerances or religious preferences, as food was cooked daily.

Staff supported patients who wanted 'home leave'. Patients were risk assessed which highlighted and concerns or barriers, and allowed measure to be put in place to facilitate the home leave. This was recorded in the patient's notes.

Anything about interpretation and translation service and leaflets/info in alternative languages or formats

Access and flow

People could access the service when they needed it. Arrangements to admit, treat and discharge patients were people-centred and in line with good practice.

The service has the facility for 60 patients. At the time of inspection there were 28 patients for acute neuro rehabilitation, 22 for continuing health care and seven for neuro behavioural rehabilitation.

The hospital received 62 referrals for admission between January and December 2018. Most (90%) of patients referred had complex disabilities. The service prioritised referrals for admission on the need of the patient and their current location. The service currently had four people on the waiting list.

When a new referral was received the admissions committee met to discuss the suitability of the patient based on the information received. If the referral was suitable a pre-assessment of the patient was arranged with members of the multidisciplinary team, appropriate to the patient's individual needs. If the referral was appropriate, the provider worked in partnership with the commissioning group and the admission process was started.

Based on the content of the referral a specialist team assessed the patient prior to admission to make sure the appropriate equipment was available to meet individual needs.

A nursing assessment was completed within 72 hours and a therapy assessment within seven days. With the permission of patients all commissioners, families (if privately funded) or insurance companies were invited to attend case conferences. The first happened after eight to 10 days following admission, a second after six weeks, and then every three months. Discharge planning was started at admission, and we saw comprehensive discharge reports were completed on discharge. This allowed for continuity of care.

Peoples relatives were able to visit, without being unnecessarily restricted. People could visit between 10 am and 8 pm. Visiting times were displayed on the notice board on reception.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, it was unclear how the lessons learned were actioned, monitored and shared with staff.

The hospital had a process for categorising and handling complaints and concerns, including an up to date 'Complaints and Compliments Policy' (dated January 2017). Staff we spoke to were aware of the complaints procedure. We saw posters on display throughout the hospital detailing how to make a complaint and how this would be dealt with.

People could make a complaint in three ways, face to face, via the telephone or in writing by either email or letter. Staff were able to describe how they would deal with a complaint; staff told us they always try to resolve any issues immediately. If issues were not resolved, the patient, relatives or carer was directed to the complaints process.

A senior manager had overall responsibility for responding to all written complaints. The hospital acknowledged complaints within two working days of receiving the complaint with an aim to have the

complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they were not, a letter was sent to the complainant explaining why.

Complaints were dealt with promptly and responses were clearly written. During the inspection we looked at four complaints. We saw the complaints we looked at were acknowledged and responded to promptly. We saw they were investigated and responses were emailed to the complainant with an apology and explanation and outcome of the investigation. All letters were written in plain English.

We saw that lessons were learned as a result of a complaint. However, it was not clear from our review how lessons learned were actioned or monitored and shared with staff.

The hospital received 10 complaints between January 2018 and December 2018.

Are long term conditions well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

The service did not have managers at all levels with the necessary experience, knowledge and skills to lead effectively. During inspection it was identified that three of the wards did not currently have a ward manager. Managers could not demonstrate adequate systems and processes that showed they had full oversight of the service in terms of risk, quality, safety, and performance.

The service had a registered manager. The Health and Social Care Act 2008 requires the Care Quality commission to impose a registered manager condition on organisations that requires them to have one or more registered managers for the regulated activities they are carrying on.

The registered manager led the management team and was supported by an operations manager. The operations manager had been in post less than a year. At previous inspection we found the registered manage maintained control of the most aspects of the hospital. At interview the registered manager confirmed they were delegating more responsibility to the operations manager, and that they had a good working relationship. The operations manager, confirmed this when we spoke with them.

The medical team, director of nursing and consultant neuro physiologist and therapy lead all reported to the operations manager.

The service did not have managers at all levels with the necessary experience, knowledge and skills to lead effectively. Three wards did not currently have a ward manager in post. The registered manager told us at interview that two of the vacant posts were currently being filled with an interim manager, which they were hopeful would take up the substantive post. However, the special care unit had not had a ward manager for a number of months.

Managers could not demonstrate adequate systems and processes that assured us they had full oversight of the service in terms of risk, quality, safety, and performance. For example, the lack of leadership with no identified person having full oversight of the special care unit. Without a ward manager, there were clear signs that some responsibilities were not covered which has weakened the governance and management systems. For example, the lack of audits, poor environment, poor cleanliness, poor fixtures and fittings and no anti- ligature works programme.

We fed this back at the end of the inspection, but the registered manager felt they had suitable arrangements to make sure patients received safe care. These included a programme of works to upgrade the special care unit, and had put additional clinical support. They told us they could only make changes when rooms were vacated. However, we were not assured that the management team had taken sufficient action to minimise these challenges.

Staff told us they felt well supported by their immediate line manager. They felt the leaders and senior staff were very approachable. If there was any conflict within the

service, they would go to their line manager and seek support. Staff told us there was a 'door always open' policy, which meant staff could approach the management team with any queries they had.

Vision and strategy

The service had a vision and mission statement for the type of care it wanted to achieve. However, the vision and mission statement were not developed with staff or patients.

The vision and mission statement for the service was based on the anthroposophical image of humans, which recognised people as being of body, soul and spirit. There was a set of values, which underpinned the vision. These included open and transparent service; to support educate staff in rehabilitation incorporating an anthroposophical approach; to provide holistic care with a multidisciplinary approach; supporting both patient and loved ones through their journey.

We did not see the vision or mission for the service on display in any of the areas where patients or visitors could see them. However, the mission for the service was on the public website.

We asked the registered manager if the vision and mission statement was developed in conjunction with staff or patients. They told us the vision was not developed with staff, but staff are reminded of the vision of the service at all training. Staff confirmed this when we spoke with them.

Culture

Staff had effective working relationships with each other. There were clear staff support networks and all staff we spoke with felt supported by their colleagues. However, staff felt they would not be listened to by senior leaders with ideas on how to improve the service.

It was clear from our observations that all staff within the service were committed and passionate about the work they did. Staff we spoke with showed a positive attitude towards delivering care that is patient centred.

Staff reported positive working relationships, and we observed staff were respectful towards each. Staff we spoke with were passionate about the service they provided; we saw that staff worked well together and supported one another during their day to day work. Staff told us, "this is the best place I have ever worked", and "the nursing staff are just wonderful, they offer so much support and this work is so very rewarding".

All staff told us they felt part of a team and felt they worked well together and supported each other. Morale appeared to be good.

The registered manager told us they had an 'open door' policy where patients and their relatives were able to discuss their care and treatment. This could be at any time, should they be happy or not pleased with their care and treatment.

However, some of the staff we spoke with thought that challenging of senior leaders was futile as the registered manager was resistant to change. They told us they had ideas on how to improve the service, but did not raise these with managers as they felt they would not be listened to.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care, but there were some areas that were not fully effective. These included the arrangements for monitoring the progress of actions from internal audits, and oversight, management and reduction of risk to patient safety.

The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Clinical governance committee (CGC), Team Leaders meetings and Operations meetings.

The service had started a daily operations meeting these were introduced to reduce potential patient harm. This meeting was attended by the leads of the services such as the registered manager, director of nursing, and operations director. This enabled them to share information and act on any risks in a timely way. Items discussed included, incidents, staffing (vacancies, leavers, sickness), the environment and complaints. We attended the daily meeting on 15 January 2019, and saw all staff present were involved and included in the discussion.

The medical advisory committee met every three months. During our inspection we looked at the minutes from the most recent committee, we saw issues such as practising privileges, incidents and complaints were discussed.

The clinical governance committee met monthly and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, complaints, compliments and training. There was also a standing agenda item to review external and national guidance and new legislation. However, we did not see the risk register discussed at this meeting. We saw there was a section for matters arising from the previous meeting, where actions were identified, with a designated person to complete them within clear timeframes. During inspection we looked at the minutes for 3 December 2018.

There were limited systems, such as auditing, to monitor the quality and safety of the service, including staff adherence to policy. Audits that were showed there was limited or ineffective action taken following an audit, where the same non-compliances were identified on multiple audits.

Managing risks, issues and performance

The organisation had systems for identifying risks, however action to reduce or eliminate them was not always carried out in a timely manner. Although there was a risk register, there was no robust way of ensuring effective risk reduction strategies had been undertaken, or all risks fully recognised.

There was a risk register to record risks within the hospital. Each risk was categorised as green (low risk), amber (medium risk), red (significant risk). The hospital had 33 risks recorded on the risk register, 31 were green (low risk), and two were amber (medium risk). The hospital had no red (significant risks) on the register.

The risk register had an explanation of the risks, but there were no named members of staff that had responsibility to make sure existing risk controls and actions were completed or maintained for each identified risk, or date for completion or review. The risk register was undated, and we did not see the risk register discussed at any of the meeting minutes we looked at. We found the risks recorded on the register provided false assurances and risk reduction strategies were not effective, and potential risks were not fully recognised.

From review of the risk register, we saw risk reduction strategies were not always in place. For example, control of substances hazardous to health (COSHH), had been risk assessed as a low risk for the hospital, and the risk reduction strategy was to make sure managers ensured chemicals were locked in designated areas. However, we found multiple concerns in the special care unit, where patients could access chemicals.

We saw infection control was on the risk register and rated as medium. However, the hospital did not recognise issues such as lack of dedicated hand hygiene facilities, carpet in patient bedrooms and bathrooms, torn flooring and furniture as risks. In addition, we saw on the minutes for quality and governance committee, dated 3 December 2018, the hospital did not have a lead for infection control. The management team had not included this on the risk register.

The risk register did not reflect all risks identified by staff. For example, staff expressed concern about the risk posed by vacancies of ward managers, and impact this had on the service they provided. We found the lack of a ward manager on the special care unit, meant there was no named person, who had full oversight and responsibility to resolve the identified issues.

We did not see other areas identified in our report, on the risk register, for example the poor environmental condition of the special care unit, including the identified ligature risks. This meant the service, did not recognise these as risks and did not have risk reduction or preventative measures to ensure patient safety.

There were limited systems or programmes for clinical and internal audit to check the quality and operational processes and systems, to identify when action should be taken.

Local audits were not always undertaken to highlight areas of poor performance or risk and we were not assured all areas risk and poor performance would be identified and action taken to address these areas. For example, there was no formal audit of hand hygiene practices. There was limited or ineffective action taken following an audit, where the same non-compliances

were identified on multiple audits. The registered manager told us they were aware of the issues with their audits and had registered with a quality assurance company, to improve their quality of auditing. However, this was not at the time of the audit and, we could not assess the impact of it on the quality of auditing and how it made improvements to the service.

Managing information

The service routinely collected, managed and used information to support its activities.

The service formally collected safety performance data. However, we did not see the safety data collected discussed in the minutes of the meetings we looked at.

Senior managers demonstrated to us they had an understanding of performance across the service and were able to give examples of how performance and patient and staff feedback were used to drive improvements across the service.

Systems and processes ensured data and notifications were submitted to external bodies. For example, statutory notifications about serious injuries were made to the Care Quality Commission.

Staff had access to up-to-date accurate information on patients' care and treatment. Staff were aware of how to use and store confidential information. Records for patients were always kept securely. An electronic system care plan system had been recently introduced in Tobias House. Staff showed us how to use the system on a mobile electronic device. Each member of staff had a unique pass code to use the system. These devices were stored securely when not in use.

Confidentiality and data protection training, was mandatory for all staff, and undertaken twice a year. Data indicated for December 2018, an overall compliance rate of 73%. The department ranged from 51% for nursing staff in the special care unit to 92% for all therapy departments. We did not have confidentiality and data protection compliance figures for medical staff. The service did not have target for compliance.

Engagement

Patients and relatives were encouraged to contribute to the running of the service, and give ideas for improvement, through regular meetings, and feedback surveys.

The hospital had a family meeting held every other month. These consisted of peer support, feedback on services and an educational training programme. Families were actively involved in choosing the topics for the meetings.

Monthly patient meetings were held, where patients and families were encouraged to discuss or express concerns or thoughts about any changes in the service, and to take an active role in planning meeting or education topics, and external trips.

The registered manager told us they have an 'open door' policy for family and patients to discuss their care and treatment, at any time, including complaints, concerns and compliments.

Patients and relatives are invited to attend the consultant's weekly ward round and all case reviews. This allowed patients to be involved in their care, and give feedback which could be instantly acted on.

The hospital acknowledged staff with an 'employee of the month' award. This was an award where staff could nominate colleagues or patients could nominate a member of staff.

The hospital held regular team meetings. Staff used the meetings for two-way information sharing. We did not see any minutes from these meeting during our inspection, but staff told us they found them useful and informative.

Learning, continuous improvement and innovation

The service was committed to improving services by promoting training, research and innovation.

The service and its staff demonstrated a willingness to develop and improve the service provided. The hospital had a strong culture of research and showed the effectiveness of its care and procedures through research. We saw that the service was involved in various local and national research and innovation development projects. These included United Kingdom Specialist Rehabilitation Outcomes Collaborative, Improving Functional Upper Limb in the real world and learning to listen.

Requires improvement

Long term conditions

We saw that members of staff attended or presented the findings at national and international conferences and had published their research in clinical journals.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that all patient safety risks are captured on an appropriate risk register, which must describe planned and completed mitigating actions.

The provider must improve the completion of mandatory training rates so it meets organisational targets.

The provider must undertake a ligature risk assessment and make sure mitigating action is put in place, including ensuring anti-ligature specification is included in any improvement schedule.

The provider must ensure the flooring and décor of walls meet the Department of Health's Health Building Note 00-09.

The provider must ensure the fixtures and fittings meet the Department of Health's Health Building Note 00-09.

The provider must ensure the infection control and environment issues identified at this and a previous inspection are addressed in a timely manner.

The provider must ensure all substances hazardous to health are stored in a secure area.

The provider must ensure clinical oversight of activity provided and ensure audit trails and quality measurement tools are in place.

The provider must take steps to ensure management responsibilities in the special care unit are adequately covered.

The provider must ensure the hazards in the special care unit garden are eliminated and it is safe for use and fit for purpose.

Action the provider SHOULD take to improve

The service should strengthen and develop audit processes to obtain more reliable, valid and accurate data, particularly regarding staff compliance with clinical standards, and ensuring non-compliances are addressed.

The service should ensure there is a standard approach to documenting best interest decisions.

The provider should ensure staff have access to emergency buzzers, and make sure these are tested regularly.

The provider should ensure the two-radios used on the special care unit are in full working order.

The service should ensure that safety dated collected is discussed at meetings and used to drive improvements to the service or patient care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (2) (a) assessing the risks to the health and safety of service users of receiving the care or treatment. (2) (h) assessing the risk of, preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) (c) suitable for the purpose for which they are being used 15 (1) (d) properly used 15 (1) (e) properly maintained

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (2) (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) (2) (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

This section is primarily information for the provider

Enforcement actions

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.