The Royal Buckinghamshire Hospital Limited

The Royal Buckinghamshire Hospital

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 18 and 19 April 2016. It was an unannounced visit to the service.

The Royal Buckinghamshire Hospital is a care home with nursing which provides care and treatment for up to fourteen people. At the time of our inspection nine people were living there.

The aim of the service is to rehabilitate people who have suffered a spinal or brain injury. They employ a team of nursing and care staff, physiotherapists, occupational therapists and have a resident medical officer (RMO) on site.

The Royal Buckinghamshire hospital has been renovated and provides accommodation on the first and second floor. The therapy department and administration offices are situated on the ground floor.

In this report the name, of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at the time. At the time of this inspection a new manager was in post and had applied to be registered with the Care Quality Commission.

We previously inspected the service on 5, 6 and 12 November 2014. The service was not meeting the requirements of the regulations at that time. Requirements were made to address our concerns. At this inspection we reviewed the progress made with the requirements from the last inspection. We saw the requirements had been met or were being addressed.

People were assessed prior to admission. A recommendation has been made to improve the way out of hours admissions are managed.

Risk assessments and risk management plans were in place. Accident/ incidents to people were appropriately managed. People's medicines were handled safely and systems were in place to pick up discrepancies in medicine administration.

People told us they felt safe. Relatives were confident people were safe. Staff were trained in safeguarding and policies and procedures were in place to support safe practice to safeguard people.

People had access to a range of healthcare professionals to promote their rehabilitation. They were actively involved and consulted with on their therapy programme and regular reviews and goal planning meetings took place to monitor their progress. People and their relatives described the therapy provided as "Outstanding, wonderful, second to none and the equipment and facilities as "State of the art".

A new care plan format had been introduced. These provided guidance for staff on how people were to be supported. People were not actively involved in their care plans and were not encouraged to contribute to

them. One person told us the care provided varied and commented "The onus is on me to instruct staff on how I like to be supported". The provider recognised they still had work to do to provide more person centred care plans.

People felt cared for. Relatives were happy with the care provided. People and their relatives described the care as "Unbelievable and real quality care". Staff were observed to be kind, caring, enabling and had a good relationship with the people they supported.

Safe staffing levels were maintained and were dependant on people's needs and dependency levels. Key roles such as ward sisters had recently been introduced to provide clinical leads on shifts. Safe recruitment practices were promoted to ensure staff had the right skills and attributes for the role. Staff were inducted and had received training the provider considered mandatory to their roles. Specialist training was being accessed and provided for staff to increase their knowledge and skills in supporting people with brain and spinal injury.

Staff felt supported although formal supervisions were not taking place regularly and annual appraisals had not yet commenced. The provider was already aware of this and had an action plan in place to address it.

The service was clean, maintained and kept in a safe condition. Plans were in place to refurbish and update the service further. Equipment was cleaned and regularly serviced.

Systems were in place to audit and monitor the service provided. The manager and nominated individual were new to post. They had identified areas for improvement and had implemented a number of positive improvements to provide a better service to people. They were keen to involve people and their relatives in the service. As a result they had introduced a patient and relative forum group and had drafted a patient handbook to provide people with key information on their admission, treatment and procedures relevant to them. This would address some of the issues raised with us by people in relation to their admission, rehabilitation programme and access to guidance on making a complaint.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's likelihood of experiencing injury or harm was reduced as risks to people were managed.

People were protected from harm because staff were suitably trained and procedures were in place to ensure staff knew what to do in the event of abuse.

People were supported by sufficient numbers of staff to meet their needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who were suitably inducted. Specialist training, supervision and appraisal of staff was being developed to promote more effective care for people.

People were supported to make decisions about their day to day care. Decisions made on behalf of people who lacked capacity were made in their best interests/ in accordance with the Mental Capacity Act 2005 and deprivation of liberty safeguards were applied for people who required it.

People had access to a range of health professionals and therapists. This ensured their health needs were met and they commenced a programme of rehabilitation.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect. Staff interacted with people in a kind, gentle and caring way.

People's privacy was promoted and their wishes and preferences

were taken into account in the way their care was delivered.

People were supported to be involved in their therapy programme and were provided with the information and explanations to enable them to make decisions on their rehabilitation.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to the admission process. Care plans were in place which provided guidance for staff on how people were to be supported. However, people were not actively involved in them.

People were not provided with the information to enable them to raise concerns and complaints however, a copy of the complaints procedure was displayed in the reception area and people felt able to raise concerns when they needed to.

People had access to person centred therapy programmes and equipment to promote improvement in their health and well-being.

Is the service well-led?

Good

The service was well- led.

Management were accessible to staff. They had identified and instigated changes to improve the service.

The service was audited and monitored to make sure it met people's needs safely. The auditing systems were being reviewed to ensure they were effective in identifying all areas for improvement.

People's records were maintained and fit for purpose.

The Royal Buckinghamshire Hospital

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 19 April 2016. It was an unannounced inspection which meant staff and the provider did not know we would be visiting. The inspection was carried out by one inspector and a specialist advisor who was a physiotherapist. They were present on one day of the inspection.

At our previous inspection on the 5, 6 and 12 November 2014 the service was not meeting the regulations inspected. This inspection was a comprehensive inspection to review the rating and progress made.

Prior to the inspection we reviewed the information we held about the service. After the inspection we contacted health care professionals involved with the service to obtain their views about the care provided.

During the inspection we spoke with five people receiving care and treatment at the service. We observed people's care and therapy sessions with their permission.

We spoke to eighteen staff which included the nominated individual, manager, three ward sisters, one nurse, five carers, three therapy staff, chef, visiting pharmacist, human resources administrator and quality manager. We spoke with three relatives during the inspection and spoke with three relatives after the inspection. We looked at a number of records relating to individuals care and the running of the service. These included six care plans, medicine records for three people, four staff recruitment files, nine staff supervision records, accident/incident reports and audits. We observed staff practices and walked around the service, including the therapy department, to review the environment people lived in and received their therapy in.

Good

Is the service safe?

Our findings

People told us they felt safe. Relatives were confident their family members were safe. One relative commented "The knowledge, skill and expertise demonstrated by all involved in my relatives care suggest to me my relative is safe".

Staff believed they offered safe care. They felt they worked together and cohesively to promote this. Staff were clear about what was considered abuse. They were aware of their responsibilities to report any incidences of alleged abuse. The provider had policies and procedures in place in relation to safeguarding. Staff told us they had received training in safeguarding adults. We looked at the training matrix. We saw all disciplines of staff had completed this training and updates were scheduled for staff who required it.

People's care plans contained risk assessments. These were person centred and addressed risks in relation to the use of bed rails, nutrition, malnutrition, pressure sores, choking and other specific risks for individuals. Management plans were in place to manage the identified risks. Staff were clear of people's risks and actions required to minimise risks. We observed staff supported people in line with risk management plans to minimise risks. Each person had a personal emergency evacuation plan in place in the event of a fire.

People's moving and handling needs were assessed by the physiotherapists. Detailed moving and handling guidance was provided by them. Alongside this people had a moving and handling care plan and risk assessment in place. However, these lacked detail and made no reference to the guidance provided by the physiotherapists which were also included in the person's file. The physiotherapists told us they demonstrated individuals moving and handling techniques to staff on duty on the day their assessment was completed. Staff confirmed this was the case. There was no record maintained to indicate which staff had been shown the moving and handling manoeuvre and it was not established who had responsibility for ensuring all staff involved in the persons care was shown how to carry out the manoeuvre safely.

One person told us it was up to them to instruct staff on their care, including how to move and handle them safely. They told us staff had moved them in a way which was not in line with the guidance provided by the physiotherapist and had caused them discomfort. The manager told us they had introduced systems to promote good communication between the therapy department and nursing staff to promote more cohesive working. They told us the nurses were involved in the weekly meetings with therapists and care staff were being encouraged to spend time in the therapy department. They recognised there was still work to do to further promote consistent care. After the inspection the provider confirmed they had recruited a clinical liaison facilitator who would be responsible for multidisciplinary co- ordination of care.

We observed a moving and handling manoeuvre on the unit. We saw staff were knowledgeable, skilled and confident in carrying out the manoeuvre in a tight space. We noted a disposable sling was used. There was no date to indicate when the sling was first used and three staff spoken with were unable to tell us the date it was first used. It was not recorded on the person's care plan file either. On visual inspection the sling had no holes or tears however the manufactures own guidance recommends disposable slings are used for a period of two weeks only. The provider confirmed this was checked on the quality walk around that took

place. After the inspection they provided us with a copy of a record they had introduced specifically to record the date the sling came into use and subsequent checks of it.

We viewed the accident and incident records. People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. Accident /incident records were completed and interventions recorded. These were checked and signed off by the quality manager or clinical nurse manager. Accident/ incidents were discussed at the weekly clinical review meeting. This enabled them to ensure preventative action was taken to prevent reoccurrence. Staff demonstrated during discussion with us they had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns.

People were kept safe from the risk of emergencies in the home. Records were maintained which showed the first aid boxes, oxygen and defibrillators were checked and fit for purpose. Staff were suitably trained to use the equipment. The home had a risk assessment document which identified environmental risks and how these were managed to promote people's, staff and visitors safety. This was reviewed and up to date. Fire safety and moving and handling equipment was regularly serviced and safe to use. A range of health and safety checks of the environment and fire safety checks, including fire drills took place. The management were keen to further improve health and safety. They had created a new role of a facilities manager and had successfully recruited into it. This staff member would be responsible for health and safety as well as managing maintenance issues. Maintenance issues were reported and dealt with in a timely manner. A relative told us the hydrotherapy pool was out of action. They did not know why or for how long. This was fed back to the management who confirmed they had three engineers look at and it had now been repaired. They agreed to review their communications in terms of updating patients and relatives when issues occurred.

Areas of the home had been refurbished and updated. Plans were in place to further improve the environment in particular the kitchen area and hydrotherapy pool. We viewed a sample of bedrooms. These were clean and nicely decorated. Some bedrooms had an en-suite shower and others had access to a communal shower which was shared with one other person. The bedrooms varied in sizes and we saw the size of the smaller bedrooms made moving and handling manoeuvre more difficult and cumbersome. A person, relatives and a number of professionals involved with the home told us the toilet and bathrooms did not have handrails which they felt was necessary in a service for people with spinal injuries. This was fed back to the provider to consider.

Cleaning staff were provided. The cleaner was clear of their responsibilities and cleaning schedules were in place and completed which showed equipment was cleaned and safe to use. People, relatives and visiting professionals told us they found the unit to be clean and well maintained. We observed the therapy staff cleaned equipment after each use. Staff were trained in infection control and clear of their responsibilities to prevent cross infection. They were aware who the infection control lead was and aware to report any potential incidents of cross infection. Staff were observed wearing protective clothing and gloves when required and kitchen staff wore the required protective clothing.

People were supported by staff to take their medicines. They told us they got their medicines when they were prescribed and pain relief was made available to them if required. People's care plans outlined how people took their medicines The registered nurses were responsible for the management and administration of medicines. They were suitably trained to carry out this task. We saw medicines were given as prescribed. Daily audits of medicine records took place which enabled staff to pick up any gaps in administration of medicines in a timely manner. Alongside this a more in depth medicine audit was completed weekly by the supplying pharmacist. They audited each medicine administration record, storage

of medicines, controlled drugs and receipt and disposal of medicines records. They outlined actions required and any issues with prescriptions they addressed with the RMO on site during their audit. A copy of the audit was made available to the manager and audit manager and they signed off actions when completed. A quarterly report was also made available to management which enabled them to pick up any trends and reoccurrences.

People generally felt there was enough staff provided to meet their needs. They told us staff were responsive to call bells and available when they required assistance. One person told us they felt the staffing levels were not sufficient and that there was sometimes a delay in a second staff member being available to assist with moving and handling. This was fed back to the manager to explore further with the person. Relatives told us they thought there was sufficient numbers of staff provided. One relative commented "Staff seem to always be available and willing to help". One relative told us their family member required one to one observations. They had concerns around how this was managed but spoke to the management and it was put right. We observed staff were available and responsive to call bells. Staff felt there was always enough staff on duty and confirmed the rota was adapted to accommodate the number of people in the service and their dependency needs.

We were told the rota was flexible and planned around the number of people in the service and their needs. The rotas reflected this was the case. During the inspection there were three nurses and eight care staff on duty. Regular agency staff were used to cover any gaps in the rota. The home employed their own therapy, catering, housekeeping and administration staff. They had access to a range of specialist consultants, external clinicians and had a doctor on site.

Some professionals told us they thought there was a high turnover of staff. The provider confirmed one nurse had left in the previous three months as they had moved out of the area. They were in the process of reviewing staff's pay and conditions to enable them to retain and attract good quality staff.

The service followed safe recruitment practices. Staff told us they had completed an application form, attended for interview and could not commence work until the required checks had been obtained. Staff files included application forms, records of interview, appropriate references and a recent photograph. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. We saw registered nurses and other professionals had their registration number checked with their professional bodies. A system was in place to highlight when a recheck was due.

Good

Is the service effective?

Our findings

People felt some staff were more skilled and had a higher level of training than others. They felt confident the staff providing their care knew what they were doing. One person told us they did not think some nursing staff and carers knew or were trained in what is required especially in relation to moving and handling. One relative felt staff were suitably trained and experienced to meet their relative's needs. They commented "Staff morale is good, this shows in everything they do". Another relative told us the agency staff when used did not seem as skilled. They commented "They did not know their relative and their relative did not respond well to staff they did not know".

Staff told us they had the training and skills they needed to meet people's needs. They confirmed they had completed an induction which included induction training and worked in a shadowing capacity alongside more experienced staff during their induction. They described the induction as "Fantastic", "Amazing " and felt the induction provided them with the training they needed to do the job. They told us they were then able to develop their skills and knowledge whilst doing the job. New staff told us they were working through an induction booklet on line which covered 16 topics. The provider told us they were working on an induction checklist specific to each role and a welcome booklet which would provide a more consistent induction for all new staff.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff completed training the provider considered to be mandatory such as Mental Capacity Act 2005, Deprivation of Liberty safeguards safeguarding of vulnerable adults, fire safety, food handling, moving and handling, health and safety and infection control. Nurses were trained in nursing tasks and procedures such as medicine administration and some nurses were trained in venepuncture (process of taking blood for sampling or setting up intravenous therapy).

Professionals told us staff listened, were always willing and made good observations. A professional commented "The nurses will always work closely with me, and I will listen to their points of view as they have a wealth of experience". Some professionals felt the nursing staff lacked training in clinical tasks, medical emergencies and specialities such as tracheostomy, mental health, spinal and brain injury. The manager told us they had met with staff to establish their training needs. They confirmed a six week course in spinal injury had commenced and was being rolled out to all clinicians. They also told us one of the ward sisters had attended bowel training which they were cascading to all the carers and key staff had been updated in spinal moving and handling train the trainer course. Alongside this they planned to develop multi- disciplinary discussion groups on themed topics on a quarterly basis including external speakers.

A professional told us the RMO's were "obliging" and would deal with emergencies quite well. They said the RMO's had regular contact with them for support by email or phone and sometimes a few times in the day. Other professionals raised concern around the training and experience of the RMO's. This was fed back to the provider who confirmed the Medical Director is involved in assessing competencies of the RMO's and has weekly clinical team meeting at which they are present. They also sign off their training/development needs and RMO's are formerly appraised on a six monthly basis by the Medical Director in line with General Medical

Council guidelines.

The nursing and care staff told us they were clear of their roles and responsibilities. They felt this had improved since the previous inspection. They said guidance and training had been provided to enable them to have clarity of roles and responsibilities. Professionals told us they felt there was a lack of clinical leadership on the unit. The manager had introduced and recruited three ward sisters. The purpose of that was to provide leadership on shifts and to have experienced staff available to support and guide junior staff as well as liaise with other professionals. Those roles were being developed at the time of the inspection and tasks were being delegated to each ward sister according to their skills and experience.

People were cared for by staff who felt supported. Staff told us they had one to one supervisions although they were not sure of the frequency. They told us they felt well supported and could go to the manager, registered nurses or therapist with any issues or concerns. We looked at a sample of supervision records. We saw there had been a gap in formal supervisions. The manager was aware of this. They had commenced a one to one session with the nurses to establish their strengths and training needs and had allocated the ward sisters and nurses junior staff for them to supervise. Supervision training had been applied for to support them in that role.

The head of the therapy departments were provided with clinical supervision from an external source. There was no evidence on their files to support this. The heads of the therapy departments provided clinical supervision to members of their teams. Therapy staff confirmed this was the case. Some files contained evidence of this and others did not. One of the therapy staff was employed by an agency. We were told their clinical supervision was provided by the agency. They had no file available and therefore there was no evidence available to confirm this had been established or was taking place. We saw some staff had evidence on file of a performance review. This was for newer staff to confirm their post. There was no annual appraisal system in place. The manager and provider were aware of that and were looking to introduce an appraisal system linked to the revised pay scale they were introducing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's care plans outlined whether they had capacity or not and people who were able to had signed to consent to their admission and treatment programme. Staff were trained in the Mental Capacity Act 2005 (MCA) and demonstrated they had a good understanding of the act.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Related assessments and decisions had been properly taken. The provider had followed the requirements in the DoLS. They had submitted applications to a 'supervisory body' for authority to do so. The DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Staff had been trained in DoLS. They had a good understanding of what it meant and knew which people had a DoLS authorisation in place.

Systems were in place to promote good communication between all levels of staff involved in people's care. On the unit a daily handover took place and tasks were delegated and allocated. A communication book was in use in the unit and all disciplines were able to write messages in it. White boards were in use in the

office and these were used to highlight individual's therapy programmes and appointments. Weekly meetings took place between the therapy department and ward staff. Regular staff meetings took place and all staff felt empowered to contribute to them. A relative told us the communication between them and all staff was fantastic. They felt staff were knowledgeable and kept the family informed of their relative's plan of care and any proposed changes to their care. A visiting professional told us they had noticed improvement in communication since the new management took over. They felt the introduction of the ward sister roles had contributed to this. Another visiting professional told us they felt communication with them could be better. They gave an example where they were not informed of changes in the care plan format. They said staff were helpful in guiding them through it but felt this should have been communicated to them along with other changes within the service prior to their visit. This was fed back to the provider to consider how external professionals are kept informed.

People, relatives and visiting professionals told us they did not know "who was who" in the staff team. They said the uniforms worn were all similar and this added to the confusion. We saw this had already been identified at a recent patient forum meeting. The provider was in the process of getting new uniforms for staff and a staff information board was on order for each unit.

People from overseas were under the care of a consultant and people from the UK were registered with a local GP service. People had access to a range of health professionals such as consultants, doctors, occupational therapists and physiotherapists. External clinicians were accessed when required for individuals such as speech and language therapists and psychologists. A weekly clinical review meeting took place to discuss individual's progress and people had weekly goal planning meetings with a therapist. People and their relatives told us they felt involved in their therapy programme, treatment and rehabilitation. They described the therapy provided as "Outstanding, wonderful, second to none and the equipment and facilities as state of the art". One relative told us there was a lack of communication between them and the consultant and they found they had to consistently chase them. They did eventually manage to speak with them. This was fed back to the provider who confirmed they would advise the consultant of the need to communicate more with patients and relatives.

A professional told us they worked well as a team of nurses, physiotherapists, occupational therapists, psychologists and they hold regular MDT meetings. They commented "We always put the patient at the centre of our discussions and all decisions involve them".

People's care plans outlined their nutritional needs and risks. They used the spinal nutrition tool which was more relevant to the people they supported. Food and fluid charts were in place for people who were considered a risk of malnutrition. The service had access to a dietitian who provided support and guidance for people who required dietitian input and provided training and guidance for staff. The provider considered nutrition screening training was mandatory and it was provided to all nursing staff during their induction.

Staff support was provided at meal times for people who required it. People told us they were very happy with the meals provided. They told us they had three meals a day and had frequent access to drinks and snacks. They confirmed they were offered a range of meal choices and could choose an alternative to what was on the menu if they wanted to. They told us the chef or one of the catering staff came to see them daily to establish their meal choice for the following day. They described the meals as "Varied, very good, tasty and nicely presented". A professional commented "Patients are complimentary about the food".

Menu plans were in place and records were maintained of meals eaten. Catering staff were aware of special diets and this was highlighted on a white board in the kitchen. Records were maintained of cooked food

temperatures and fridge and freezer temperatures. These were generally well maintained. The service had recently received a four star rating under the food hygiene rating system as a result of an environmental health inspection.

Good

Is the service caring?

Our findings

People described staff as kind and caring. One person commented "Their heart is in the right place, they really do care and I do not have a bad word to say about them".

Relatives told us they were happy with the care. They described all the staff as caring, kind and empathetic. One relative told us one of the carers had a fantastic relationship with their relative and this staff member comes in on their day off to take their relative into the hydrotherapy pool. They commented "They go the extra mile". Another relative told us the staff had become part of their family. They described the care as unbelievable and real quality care. They told us staff were genuinely kind, caring, compassionate and passionate about what they do. They commented "Staff know my relative really well. I feel they are truly well looked after".

Professionals involved with the home told us staff were helpful, friendly, welcoming and one professional described staff as "Genuinely caring". They said you can see that in the connection they have with people they support. Another professional described the staff as empathetic and gave an example where staff approached the professional to have some flexibility with the rehabilitation programme for an individual who had a set-back during their programme.

People's dignity was respected by staff. We observed staff interacted positively with people. They appeared kind, gentle and caring in their approach. They actively involved people in their care. They obtained consent, gave choices and always promoted and encouraged people's independence without exceeding their capability with the task in hand. They provided people with good eye contact, reassurance and encouragement whilst engaging and supporting people. Staff were patient and allowed people plenty of time to complete tasks such as mobilising, eating and drinking.

Brochures were available in Arabic and English. The provider confirmed the new patient handbook being developed would also be made available in Arabic and English and developed in other languages as the business expanded if required. Interpreters were available for overseas admissions. The service also had access to an Arabic speaking Speech and Language therapist who supported people's rehabilitation programme. This promoted people's understanding and involvement in their care.

People's visitors were made welcome and were free to visit any time of the day or night. Visitors were able to stay overnight if they wished to. People told us staff were very accommodating in enabling this to happen. Relatives told us staff were always very welcoming. One relative commented" Staff come in with tea, biscuits and drinks for the children, this is very much appreciated". The service catered for people who had cultural and religious needs. We saw that these were respected and catered for.

People told us their privacy and dignity was respected. They told us staff knocked on their bedroom doors prior to entering. People were addressed in the way they liked to be addressed and called by their preferred name/title. We observed staff were respectful towards people. They always acknowledged people and were discreet and courteous during conversations with people which promoted their privacy and confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to their needs. They gave examples where their therapy programme was adapted to take into account any setbacks they had. People and their relatives could see the improvements and progress they had made. One relative commented "They have allowed us a family to have a life and given my relative his life back". Another relative commented "My family member has definitely made progress".

A professional commented "The whole ethos of the place is 'yes, we can'. There is a positive atmosphere within it".

We observed during therapy session's staff responded appropriately and safely to people's abilities. They recognised when people were struggling and adapted the programme accordingly. The outcome of each therapy session was recorded on their records.

People who lived in the UK had their needs assessed before they moved to the service. The assessment was carried out by the manager or a senior member of the team. For overseas admissions written information was obtained prior to admission. On admission people were seen by the RMO on duty and a full assessment was completed. Alongside this the nurses completed their assessment and care plans were put in place. People were assessed by the physiotherapists as soon as possible after admission and a moving and handling plan agreed. Further detailed assessments were carried out by various members of the therapy team over the first few days of admission and a rehabilitation plan agreed with the person.

The service prefers new admissions to take place before 17.00 hours weekdays and not at the weekends. This is to ensure the relevant professionals are available to assess people and ensure the right care is prescribed. We saw a recent admission had taken place outside of those hours which was outside of control of the service itself. The admission was pushed for by the family as they did not want their relative to remain in the referring hospital for another day. The person described their admission as chaotic and commented "The first 24 hours were hell". This was due to them not being able to be moved into a position which they found comfortable as the moving and handling assessment had not been carried out. We saw the nursing staff liaised regularly with the doctor on call during the night in an attempt to alleviate the discomfort for the person. Therapists told us that occasionally people are admitted at night or over the weekend. They said this may result in them not being assessed by a therapist on the day of admission, but nursing staff do not undertake the manual handling assessment. This may result in the person having to stay in bed until an assessment can be completed which was the case for one of the people we spoke with. The manager acknowledged this was not ideal and agreed to consider how out of hours admissions when they do occur can be better managed to promote the comfort and safety of the person.

A professional told us overseas admissions were not always suitable or medically fit for admission. This was fed back to the provider who told us there had been an occasion in the previous year where an admission had been deemed to be medically unfit. As a result appropriate discussions and documentation are now sought by the Medical Director prior to the acceptance of the patient to the service and before allocating an

appropriate admitting consultant. They felt this was an identified potential risk for any admission and they mitigate appropriately and if necessary transfer to a local hospital.

A relative told us the admission assessment did not take account of what was happening in the person's life/ family prior to admission and that was not taken into account in how they as a relative were coping. The provider told us they had implemented a "This is me" form in the notes and agreed to explore with patients and relatives how it could be further developed to provide a better patient relationship. They told us they had also arranged training for the nurses and carers to provide them with assessment skills to encourage people and their relatives to open up. Another relative told us they were not provided with any information on admission on what to expect during their stay. The provider confirmed they had already recognised this was an issue. We saw it had been discussed at a recent patient forum meeting. They confirmed a draft handbook was being devised that patients and their relatives would get the chance to comment on before going to print.

It is recommended the provider reviews their admission procedure so that out of hours admissions are properly managed, to ensure they can meet the persons' needs and promote their safety and comfort.

The manager had introduced a new care plan format and these were being developed and improved on with the intention being to introduce electronic care plans. All professionals involved in people's care were expected to write up their engagement with people within the care plan to promote more cohesive working.

People had a range of care plans in place to address their needs. Care plans outlined how people were to be supported with their needs and any risks associated with that. These were kept under review and updated. People told us they were offered person centred care and felt involved in their care. However their care plans did not reflect that. We saw people had to sign to consent and agree to their rehabilitation programme. However none of the people or relatives we spoke to knew care plans existed and had no involvement in their development, despite some people having capacity to do that. One person told us the care provided varied and was dependant on the staff member and their experience. They commented "The onus is on me to instruct staff on how I like to be supported". The provider confirmed after the inspection that people and their relatives would be more involved in their care. It was felt the appointment of the clinical liaison facilitator would enable this to happen.

Each person had a named therapist. The manager had recently introduced a named nurse system. However people and their relatives were not aware who their named nurse was or what that role meant to them. The manager told us this was something they had recently introduced and were keen to develop further. They confirmed this information was available on people's notice boards in their bedrooms.

Relatives told us they were not clear about the frequency of the multi -disciplinary team (M.D.T) meetings. Two relatives told us they had not had one for some time although the nursing staff kept them informed and updated. The provider told us the frequency of M.D.T meetings depended on whether the patient was undergoing intensive rehabilitation therapy for new and short term patients or maintenance therapy for longer stay patients. They agreed they would include a summary of this within the patient/ relative handbook.

People's care plans outlined their communication needs and any support required. People were provided with aids and equipment to promote their communication. We observed and heard staff consistently use equipment provided when engaging with a person. They also demonstrated a good understanding of the person needs and were responsive to them. One relative commented "Couple of carers who are instrumental in improving my relative cognitively. They take the time to engage with them and this

encourages my relative to respond and communicate which they need to do". A professional involved with the home told us staff work to the programmes they put in place for people to promote and encourage their communication. Another professional told us they provide guidance for the person and their relative but not necessarily for staff, however they write a summary of their engagement with the person in their care plan. The provider told us it is every professional's responsibility to highlight any recommendations in change of care they have made to the nurse in charge of the shift. They have clinical meetings every Monday which reviewed any changes made by the wider MDT.

Professionals told us they thought communication within the team was good. They were aware staff had a detailed handover which they felt contributed to that. They told us during their visits staff were always responsive to their requests for information, assistance and in carrying out their instructions. Other professionals told us communication with some members of the team was limited as English was not their first language.

Each person had a weekly rehabilitation programme. People were provided with a copy of the programme and knew what was scheduled. Care staff supported people to attend their programme. People told us there was always sufficient staff available to make sure this happened. People had access to intensive therapy on site which included physiotherapists, occupational therapists and state of the art equipment to promote and enable a person to mobilise. There was a hydrotherapy pool and facilities to enable people to use life skills such as making drinks, cooking and laundry. People and their named therapist had regular goal planning meetings which promoted responsive care.

People and their relatives were not provided with a copy of the complaints procedure and did not know if one existed. People told us they would talk to the nursing staff, the doctors or therapists if they had any concerns or complaints. They told us any issues raised by them had been addressed in a timely manner and to their satisfaction. The home had a complaints procedure in place. A copy of the complaints and concerns procedure was displayed on the notice board at the entrance to the reception. It was available in English and Arabic and accessible to people. We looked at the complaints log. Complaints were logged, investigated and responded to. Any complaints received were reported to the weekly clinical meetings and action taken to prevent reoccurrence. The management told us they were in the process of introducing a patient handbook and the complaints procedure would also be included in that.

Good

Is the service well-led?

Our findings

The service had a new manager that had applied to the commission to be registered. The nominated individual was also new to the role.

We received mixed feedback on the management of the service. Staff told us the service was well managed. They were very positive about the change in management and could see the improvements they had made. They felt involved, consulted with and felt they were provided with the training and guidance they needed to do their job. They told us the manager was accessible, approachable and provided hands on care if required. The manager worked on the unit, was in uniform and had a visible presence to staff.

People and their relatives spoken with were not aware who the manager was. They told us the manager had not introduced themselves to them and they did not feel the manager had a visible presence on the unit and especially to relatives and their families. One relative commented "Management definitely needs looking at and improving". Another relative told us they were not aware of the management changes and the change of management had not impacted on their relatives care. This was fed back to the provider who acknowledged they had initially focused on meeting with staff, improving staff practices through training and guidance and the introduction of key roles within the staff team to support staff moving forward. They told us future key appointments would be notified through the patients and relatives forum, newsletter and their website. They also agreed that from now on the management team will introduce themselves to patients and relatives within a week of their admission.

Some professionals told us they were not informed of the change in management. The provider told us they met with individual professionals to update them on the change, however they recognised some professionals provide a service out of hours so may not have had that communicated to them. The provider told us they planned to introduce a quarterly newsletter for staff which will highlight changes.

A professional involved with the home told us they had seen many positive changes since the new management had been in post. They felt the introduction of clearly defined roles such as the ward sister roles meant communication had improved. They told us the new management team were receptive to suggestions made by them to further improve the service such as providing staff with training in mental health. Another professional told us the service had come a long way since the previous inspection. They felt the new management had already made positive changes and they were aware more changes were planned. They commented "I have no doubt that the recent changes in management have made a big difference and will ensure that the place provide the type of service that we as individuals are happy for our families and friends to use. I am confident that the direction of travel is in the right direction". A third professional told us they believed the service was well-led as the managers were always open to new ideas. They gave an example of an idea they had to use digital technology in out- patients which had been taken on board and a meeting had been arranged with management to move their idea forward.

The manager was a positive role model to staff. They were experienced, committed and motivated. They were clear of their role and what they wanted to achieve. They had identified areas for improvement through

their observations and one to one discussions with staff. They had prioritised what needed doing such as training the staff team, introducing new roles and improving the care plans. They recognised they still had work to do to further improve the service.

The provider was aware of their registration responsibilities. They are required to notify CQC of significant events such as accident/ incidents concerning people who use the service. They had notified CQC about significant events. We used this information to monitor the service. From these we were able to see appropriate action had been taken.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. A new quality monitoring tool had been developed which was in line with the five key questions that CQC's inspections and reports are based on. Internal audits such as audits of medicines, care plans, accidents, incidents, health and safety, infection control, complaints and training of staff were taking place. Action was taken to address shortfalls. The provider also regularly monitored the quality of care at the service. An external auditor audited the service quarterly and the provider was looking at ways of further improving the governance of the service.

Systems were in place to get feedback from people at the end of their treatment. This was been developed to get feedback from people and their relatives throughout their stay. They had recently introduced a patient forum meeting and feedback and suggestions from that were being acted on. The provider told us they had plans to develop this further with the introduction of a quarterly staff and patients newsletter and they planned to implement a patient and relative zone on their website. This would promote people and relatives involvement and keep them informed. There was currently no system in place to get feedback from others such as professionals. The provider agreed to review this.

Records required for regulation were accessible, suitably maintained, secure and up to date. Staff had access to general operating policies and procedures which provided them with up to date guidance to promote safe practice.