

Thames Brain Injury Unit







Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Thames Brain Injury Unit as good because:

- The management team had made improvements to the service since our previous inspection in October 2016. The maintenance of equipment and management of medicines was now safe. Staff had made improvements in care planning and learning from incidents. Arrangements for the safety and privacy of female patients had improved.
- The multidisciplinary staff team worked positively to ensure good outcomes for patients. Staff assessed and managed the care and rehabilitation needs of patients well. The service provided care and therapeutic interventions in line with good practice guidance. Staff effectively supported patients to regain their skills and independence following an acquired brain injury.
- The staff team reviewed and managed risks to ensure the safety of patients and there was sufficient staff cover to meet the needs of patients.

- Staff were proud to work in the service and reported that the management team listened to them.
- Patients told us that staff were caring and kind. They said staff had the skills to support them to recover and regain their independence.

However:

- The management team recognised that further work was required to improve clarity for staff on the location of information in the paper and electronic records.
- Staff sometimes entered patient bedrooms without knocking first.
- Although patients liked the range of food on offer, some patients said it was too salty.

Summary of findings

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Good



Thames brain Injury Unit

Services for people with acquired brain injury

Summary of this inspection

Background to Thames Brain Injury Unit

Thames Brain Injury Unit is provided by Huntercombe Properties (Frenchay) Limited. It is one of two units that form the Blackheath Brain Injury Rehabilitation Unit.

Thames Brain Injury Unit provides 17 beds for male and female patients. At the time of the inspection 15 patients were using the service. The Thames Brain Injury Unit is registered with the CQC to carry out the following activities:

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

- accommodation for persons who require nursing or personal care.

NHS England commission the service to provide an intensive period of rehabilitation of up to 180 days for patients who have mental health and physical health needs resulting from an acquired brain injury. Patients using the service are admitted from an acute hospital and most return to their own home after rehabilitation.

There have been eight previous CQC inspections of the Thames Brain Injury Unit. At the last inspection in October 2016, four regulatory breaches were identified. The service has a registered manager.

Our inspection team

The team that inspected Thames Brain Injury Unit comprised two inspectors, an assistant inspector and one specialist registered nurse advisor with knowledge and experience of the care and treatment of patients with acquired brain injuries.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before this unannounced inspection visit, we reviewed information that we held about the location. This inspection was unannounced. During the inspection visit, the inspection team:

- observed the interactions between staff and patients
- spoke with seven patients and one family member/carer of a patient
- interviewed the hospital director and other members of the senior management team
- spoke with seven other staff members including registered nurses, doctors, rehabilitation assistants, therapists and a social worker
- checked the safety and cleanliness of the service
- observed a clinical governance meeting
- reviewed seven care and treatment records
- checked 15 prescription charts

Summary of this inspection

- checked how staff stored and managed medicines
- read audits, meeting notes, procedures and other documents relating to the service.

What people who use the service say

Patients told us that staff were kind and respectful. They said staff listened to them and took their views into account. Patients felt safe in the service. Patients said staff had helped them to understand the impact of their acquired brain injury and how to be as independent as possible.

Patients were very positive about the therapy they received. They told us how they had become more independent. For example, patients said that staff had supported them to learn to walk again and how to ensure they remembered important appointments.

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?

We rated safe as good because:

- The safety of the service has improved since our previous inspection in October 2016. At this inspection, we confirmed that medicines were now stored safely and equipment was serviced appropriately. Staff effectively learned lessons from incidents and made changes to improve the safety of the service. The provider had made changes to ensure same sex accommodation requirements were met.
- There were sufficient numbers of nursing staff to meet the needs of patients. Staff were up to date with appropriate mandatory training.
- The staff team assessed, reviewed and managed risks to keep patients and others safe.

Good



Are services effective?

We rated effective as good because:

- Since our previous inspection, the service had made improvements to provide effective care and treatment for patients. Care planning had improved in the service. Staff understood where information could be found in the electronic and paper records. Staff understanding of the implementation of the Mental Capacity Act had improved.
- Multidisciplinary team work ensured that patients received care and rehabilitation which complied with best practice guidance. The staff team provided therapy and care which supported patients to regain their independence and return home.
- The staff team met the physical healthcare needs of patients.
- Staff received clinical supervision and there were regular team meetings.

However:

- The management team recognised that further work was required to improve clarity for staff on how they should use the paper and electronic records.

Good



Are services caring?

We rated caring as good because:

Good



Summary of this inspection

- The service had improved since our last inspection. Staff now ensured that they could not be overheard when discussing patient care.
- Patients said staff were caring and kind and fully involved them in planning their recovery.

However:

- Staff sometimes entered patient bedrooms without knocking first.

Are services responsive?

We rated responsive as good because:

- The service worked well with commissioners of the service to plan admissions and discharges. Most patients were discharged within the target timeframe of 180 days.
- Patients knew how to make a complaint. An advocate supported patients to raise concerns. The management team made changes in response to feedback from patients.
- Patients participated in a range of therapeutic and leisure activities.

However:

Although patients liked the range of food on offer, some patients said it was too salty.

Good



Are services well-led?

We rated responsive as good because:

- The management team had implemented changes and improved the service since our previous inspection.
- Staff morale was positive. Staff told us that the management team listened to their views and supported their learning and development.
- There was a robust quality assurance framework and managers of the service were aware of the areas of the service which required further improvement.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

- At the time of this inspection, there was one patient in the service who was detained under the Mental Health Act. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Training records confirmed that over 85% of staff had received training on the Mental Health Act.
- Staff told us about the steps they had taken to ensure the patient was informed of their rights and visited by an Independent Mental Health Act advocate. They had also supported the patient to take their approved leave.
- There were appropriate arrangements in place to ensure that the necessary paper work was in place to comply with legal requirements.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act and the five statutory principles of the Act. We read training information which confirmed that over 85% of staff had received training on the Mental Capacity Act. In addition to this on-line training, the service's social worker held weekly sessions for staff to discuss practice in relation to supporting patients who may lack mental capacity.
- Capacity to consent to care and treatment was routinely assessed on admission to the service and recorded in the care and treatment notes. Where a patient lacked the mental capacity to consent to treatment, the service completed referral documents for a Deprivation of Liberty Safeguards authorisation to the relevant local authority. At the time of the inspection, five patients were subject to authorised Deprivation of Liberty Safeguards. The social worker had oversight of the operation of Deprivation of Liberty Safeguards in the service, and liaised with the local authority to ensure applications were progressed.
- Staff understood the principles of the Mental Capacity Act. Staff supported patients to make decisions when they had the mental capacity to do so. The mental capacity of patients usually improved whilst they were at the service, so staff said they often waited until they could decide for themselves.
- Staff worked with patients to promote their understanding, for example they understood that information may have to be repeated because patients had memory problems. Patients told us that staff explained their care and treatment in terms that they could understand.
- Staff gave an example of a patient who was resistant to support with their personal hygiene and who lacked the mental capacity to make decisions about this. Staff worked with the patient's family to develop strategies to support the patient and deliver care in the least restrictive way.
- Care records showed that the staff team checked that patients had the mental capacity to manage their financial affairs. Staff liaised with the patient's family and other agencies as appropriate to ensure that the patient's finances were managed safely.

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Good 

Safe and clean environment

Safety of the ward layout

- At the previous inspection in October 2016, we found that the service did not comply with guidance in relation to same sex accommodation. The designated female lounge was inappropriately placed next to the entrance to the unit. Therefore, female patients did not have a free, safe space as male patients and staff used this space for their own purposes. At this inspection, we saw that the provider had made improvements. The service had created a new female lounge in the main ward area solely for use by female patients.
- Staff assessed risks to patients and staff arising from the layout of the service and mitigated these. Staff carried out individual patient risk assessments, planned how they would observe each patient to ensure their safety and made regular checks of the ward. There was an up to date ligature risk assessment in place. This explained to staff the location of potential ligature anchor points and what actions were in place to mitigate risks.
- There were curved mirrors in the corridors to assist staff to observe patients. Due to the layout of the bedrooms it was hard for staff to visually check that patients were safe. The psychiatrist told us that the design of the unit meant that it was not suitable for patients at high risk of self-harm or suicide. Consequently, patients with such risks were not admitted to the unit.

- The staff team met daily to review the individual risks to each patient and decide how those risks should be managed. Staff fully understood the current level of risk for each patient and how to manage those risks. Where patients had a high risk of violence and aggression staff provided one to one observation to keep them safe.
- Staff and visitors to the service were issued with personal alarms to use in an emergency. Staff tested alarm systems to ensure they worked well and staff responded appropriately. There were also tests of fire safety equipment, and fire drills had taken place.
- The entrance to and exit from the unit was controlled by staff.

Maintenance, cleanliness and infection control

- The service was clean and well-maintained throughout. Staff carried out health and safety checks and implemented fire safety procedures. Staff completed infection control audits to reduce the risk of infection.

Clinic rooms and equipment

- At the previous inspection in October 2016, we found that staff did not service some medical equipment to ensure safety. At this inspection, we found there had been improvement. Staff had ensured that all equipment blood pressure monitors was appropriately serviced. The clinic room was tidy, clean and well-equipped.
- Staff made checks to ensure that medicines and equipment for use in an emergency were readily available and safe to use. For example, staff had promptly acted to order a new battery for the

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defibrillator. However, on some occasions staff had omitted to complete the second page check-list they used to audit equipment. This had not affected the safety of equipment.

- The practice development nurse offered weekly training for staff and ran simulation medical emergencies to prepare staff to respond to such situations.

Safe staffing

Nursing staff

- There were a significant number of vacancies for permanent registered nurses and rehabilitation assistants. In the 12 months period ending 30 June 2018, the average vacancy rate was 44%. Vacancies, leave and sickness were generally covered by bank staff and agency staff. In the period 1 April 2018 to 30 June 2018, agency staff were used to cover vacancies, leave and sickness on 584 occasions. Some agency staff were retained by the provider on short-term contracts to promote continuity of care. Patients said that therapy staff were consistent and knew them well.
- Turnover in the service was high. In the 12 months up until 27 July 2018, 17 of 38 staff had left the service, giving a turnover rate of 44%. There was a continuous process of recruitment. The hospital director told us the terms and conditions of employment were comparable with other providers and there were plenty of applicants for vacancies. The service was using performance management systems to ensure staff were competent.
- The service used values based recruitment procedures and it took time for staff to complete all stages of the recruitment process. The recruitment process aimed to ensure that staff would have the appropriate skills and attitude to work in a rehabilitation service for patients with acquired brain injury. The service had recently recruited 11 rehabilitation assistants who were in the process of going through the required recruitment checks. Once these staff were in post there would be a significant reduction in vacancies.
- Staffing levels were reviewed and adjusted to ensure the safety of patients and staff. Staff told us that managers arranged additional staff to provide one to one observations when there were high levels of risk.

Medical staff

- A full-time consultant neuropsychiatrist and a junior doctor provided medical cover across the service. Patients were registered with a local GP who attended the service each week. Staff told us the service had effective out of hours arrangements, during which a doctor could attend the ward in an emergency.

Mandatory training

- The service provided all staff with mandatory training in key skills required to carry out their roles. The hospital director closely monitored the take up of mandatory training. At the time of inspection overall completion rates for mandatory training were high at over 85%. The regular agency staff used by the service had been assessed by managers as competent to work with patients with acquired brain injury.
- Mandatory training covered relevant issues such as risk assessment and reducing violence and aggression. Staff said they could easily access mandatory training and were clear on which courses they must complete.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed seven care and treatment records. The staff team clarified risks prior to admission and ensured that the service did not admit patients unless their needs could be safely met. There were daily multidisciplinary meetings to ensure that staff had an up to date understanding of the current risks.
- The consultant neuropsychiatrist visited patients referred to the unit in their hospital ward to carry out a face to face assessment. They also spoke with the staff team caring for them to clarify risks. Staff did not admit patients assessed as at risk of suicide to the unit.
- The service completed an initial risk assessment when patients were admitted. This set out any risks in relation to the patient's physical and mental health and risks to the safety of the patient and others.
- Notes of the daily multidisciplinary team meeting showed recent risk incidents were discussed and there was action planning to ensure that they were appropriately documented and followed up. Staff also clarified risk issues for each patient at handovers between nursing shifts.

Management of patient risk

Services for people with acquired brain injury

- Both permanent and agency staff that we spoke with demonstrated a thorough understanding of the risks associated with brain injury and how to work with patients to reduce risks. For example, they could explain risks due to patients having difficulty with communication, memory and problem solving.
- Some patients had behaviours which challenged the service and could be verbally aggressive when they were anxious. The staff team recognised that new patients were often distressed and disorientated when they first came to the unit. They ensured that new patients received one to one support for at least the first day on the unit and then reviewed risks and adjusted observation arrangements after that.
- Staff identified and responded to emerging risks. The staff team planned how to manage risks at handover and multidisciplinary meetings. When necessary, the staff team adjusted staff numbers so patients could be observed on a one to one basis to reduce risks.
- There were no blanket restrictions in place. For example, patients could keep a mobile phone and charger in their bedroom. Staff said they evaluated risks to each patient on a case by case basis. Patients could access drinks and snacks at any time.
- Staff completed training in prevention and management of violence and aggression. This included safe restraint techniques. Staff used de-escalation techniques when patients were distressed. For example, they told us they calmed patients who were agitated by talking with them about topics that interested them such as their family. There had been no incidents of physical restraint or seclusion in the twelve months prior to the inspection.
- Patients could go to their rooms when they wished. Female patients told us that changes to the ward layout to promote sexual safety meant that they now had to ask a member of staff to allow them back to the area of the unit where the female bedrooms were.
- Staff held a reflective meeting at 2pm every day to discuss how the day was going for staff and patients, and to get a sense of the level of stress in the service. This meant that staff could address situational risks more effectively.
- Staff fully understood multi-agency procedures to protect patients from abuse and worked effectively with the local authority and other agencies. Staff could explain what types of incident should be reported as a safeguarding incident and how to make a referral. The service's social worker communicated directly with safeguarding leads in the local authority about referrals and the progress of cases.
- When there were incidents between patients, staff appropriately reported into multi-agency safeguarding systems which included the local authority and the police. Patients told us they felt safe in the service.

Staff access to essential information

- Staff used an electronic database for care and treatment records and additionally kept paper records. Both permanent and agency staff said they could locate information when we asked to see it.
- Staff used paper records to inform how they should provide care. Care plans written by therapy staff were in a folder in the patient's bedroom. A patient's diabetic care plan which had been written by the patient's diabetes treatment team was attached to their prescription chart. There was no mention of the diabetic care plan in the electronic records.

Medicines management

- Staff followed good practice in medicines management. They ordered, stored, dispensed and disposed of medicines safely and securely. At the previous inspection, medicines were not always managed safely. Medicines were in boxes on the floor of the clinic room. There was a risk that medicines may not have been accounted for. At this inspection, there had been an improvement. Staff stored medicines appropriately and fully accounted for them.
- We checked 15 prescription charts. Staff had completed the charts to show that patients had received their medicines as prescribed.
- The service commissioned a pharmacy company to supply medicines and make checks of practice. The pharmacist made regular audits of medicines storage practice and checks of prescription charts. Additionally, staff carried out checks and audits to ensure that

Safeguarding

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medicines were stored correctly and safe to use. They monitored the fridge and room temperature where medicines were stored. Controlled drugs were stored and managed appropriately.

Track record on safety

- Between 1 March 2017 and 28 February 2018, the service reported one serious incident. This incident had been fully investigated and an action plan implemented from the lessons learnt.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to make reports. The service ensured staff learned from incidents to improve the service.
- Notes of daily multidisciplinary meetings included details of recent incidents and confirmation that they had all been reported onto the provider's database for incidents. Staff said that whenever they logged an incident on the database they went over the incident form with a manager to ensure that all appropriate details of the incident were recorded. Incidents reported included, verbal aggression from patients to other patients or staff. Staff routinely completed behaviour charts to help them to identify the causes of a patient becoming agitated or distressed.
- Staff discussed incidents and the lessons learnt during morning briefing meetings, in monthly team meetings, by email, and by looking at the white board in the nurses' station, where lessons learnt were clearly displayed. Staff told us that on returning to work for leave or sickness, managers informed them of incidents which had occurred whilst they were away.
- Staff could give examples of recent incidents and the learning from them. Staff told us of a patient who had recently been physically unwell and then attended the local accident and emergency department. The learning from the incident related to the importance of the close observation of patients and identifying any changes in a patient's behaviour which may indicate that they are not well.

- Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with patients if something goes wrong.

Are services for people with acquired brain injury effective? (for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We reviewed seven care and treatment records. At the previous inspection we found that there were delays in staff completing patient care plans comprehensively. At this inspection we found that staff continued to use both electronic records and paper records to record different aspects of care planning for the patient. The electronic database did not have comprehensive care plans which explained the patient's physical health needs for example. In practice, staff used the paper records to plan and deliver care to the patient. The information on the paper record was up to date. Staff we spoke with knew where to find information. Managers told us they were aware of this issue and were in the process of making improvements to care planning in the service.
- The staff team assessed patients face to face prior to admission. They aimed to clarify whether the patient could benefit from a short-term rehabilitation programme. The staff team also checked that the service could meet their mental and physical health needs. Staff told us that they felt that pre-admission assessment processes had improved. Previously, some of the patients admitted to the service were unable to benefit from the service's rehabilitation programme. Staff said that now most patients soon started to become more independent in response to the care and treatment they provided.
- Staff assessed and managed the physical healthcare needs of patients. For example, staff supported a patient living with diabetes in accordance with a care plan which covered their diet, medicines and the monitoring of their blood sugar levels.

Services for people with acquired brain injury

- Some patients had needs in relation to their mobility which were assessed by a physiotherapist on admission. The multidisciplinary staff team decided what type and the frequency of physical health checks each patient should have. For example, staff checked the weight and body mass index of some patients each week because there were concerns about them maintaining a healthy weight.
- Care plans were holistic, recovery-oriented and personalised. Paper care plans were tailored to the needs of the individual patient and identified clear goals in terms of their rehabilitation and recovery. These plans explained what nursing staff and rehabilitation staff should do to support the patient to relearn and practice their skills. For example, in relation to their personal care. Staff said communication between therapy staff and nursing staff had improved since the previous inspection. They said this ensured that the team worked together to promote the patient's recovery. Care plans addressed physical health needs and were updated as necessary.
- A dietitian visited the service and gave advice on nutrition if a patient was not a healthy weight or had problems in relation to food and drink. The speech and language therapist also helped patients with communication skills and assessed any swallowing problems.
- Therapy staff used various rating scales to monitor each patient's progress in terms of their rehabilitation and preparation for discharge. Occupational therapists used functional independence measures to assess the patient's ability to do everyday tasks such as self-care, cooking and domestic tasks. Psychologists used outcome measures such as an orientation log at the start and end of admission, as well as an anxiety and depression tool, and an awareness questionnaire, which assessed patient insight into their brain injury.
- Staff completed clinical audits to check the quality of record keeping and compliance with good practice standards. Managers had identified areas for improvement from these audits. For example, they told us that they were working with staff to improve record keeping in relation to patient views on care plans.

Best practice in treatment and care

- A multidisciplinary staff team provided the range of care and treatment interventions recommended by the National Institute for Health and Care Excellence (NICE). The staff team was led by a consultant neuropsychiatrist and included physiotherapists, occupational therapists, speech and language therapists, psychologists and a social worker as well as nursing staff. On admission, therapists assessed each patient's strengths and areas for development and completed care plans for the staff team to follow. For example, psychologists evaluated the patient's cognitive functioning and developed plans to improve the patient's orientation, attention and planning processes. Electronic care notes showed that therapists regularly reviewed the patient's progress and ensured they were fully supported to develop their skills and become more independent.
- A GP provided a weekly clinic at the service. Staff could call the out of hours GP on call service. Care and treatment records showed that staff attended to the physical health of patients and ensured they received appropriate follow up from the GP or at the local acute hospital.

Skilled staff to deliver care

- The staff team included the full range of specialists required to meet the needs of patients. This included a neuropsychiatrist, registered nurses, psychologists, speech and language therapists, occupational therapists and a dietitian.
- Patients were very positive about the specialist skills of staff. For example, they told us how the physiotherapist had helped them to start to walk again.
- Registered nurses and rehabilitation assistants were supported by the practice nurse to develop their skills and knowledge. Staff told us that they felt they had good training and advice from the rest of the staff team on meeting the needs of patients. For example, occupational therapists delivered practical training sessions on the safe manual handling and positioning of patients with mobility problems.
- Therapists told us the provider supported them to develop their skills through attending specialist training,

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peer support initiatives and clinical supervision. For example, psychologists in the team held a monthly professional development meeting to share best practice.

- There was comprehensive induction for new staff which orientated them to the service and informed them of the provider's values and expectations.
- The provider set a standard of clinical supervision occurring every eight weeks. Data showed this standard was fully met and staff received an annual appraisal. Staff told us they felt supported by their managers and had the opportunity to raise any concerns with their manager.
- Staff said managers addressed any issues of poor staff performance.

Multidisciplinary and interagency team work

- Staff in the multidisciplinary team worked together effectively to ensure best practice. Staff told us that communication between the disciplines in the staff team had improved since the last inspection. Occupational therapists and psychologists felt confident that nursing staff would fully implement plans to promote the independence of patients. Nursing staff said therapy staff respected their views and they were fully involved in the planning and delivery of effective interventions to promote the recovery of patients.
- A multidisciplinary meeting took place each morning. Staff discussed incidents from the previous day and the plans and activities for individual patients. A weekly clinical team meeting reviewed each patient's progress and planned for the discharge of the patient.
- The service worked in close collaboration with commissioners and case managers from NHS England. This ensured that admissions and discharges went as smoothly as possible. There was a monthly team meeting to discuss incidents, safeguarding concerns, complaints and lessons learned.
- The service held a clinical governance meeting every month to go through the needs of staff and patients at the service. We observed a meeting and found that it was well structured, and focussed on setting goals and achieving outcomes. The meeting covered recruitment, training, new policies and procedures incidents, safeguarding referrals, and complaints. Staff reviewed

the new training schedule for rehabilitation and looked at the new protocol regarding children visiting the service. An advocacy representative attended this meeting to go through the themes regarding staff behaviour, which the patients had brought up during the previous month.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- At the time of this inspection there was one patient in the service who was detained under the Mental Health Act. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. We read training information during the inspection which confirmed that over 85% of staff had received training on the Mental Health Act.
- Staff told us about the steps they had taken to ensure the patient was informed of their rights and visited by an Independent Mental Health Act advocate. They had also supported the patient to take their approved leave.
- There were appropriate arrangements in place to ensure that the necessary paperwork was in place to comply with legal requirements.

Good practice in applying the Mental Capacity Act

- Staff had a good understanding of the Mental Capacity Act and the five statutory principles of the Act. We read training information which confirmed that over 85% of staff had received training on the Mental Capacity Act. In addition to this on-line training, the service's social worker held weekly sessions for staff to discuss practice in relation to supporting patients who may lack mental capacity.
- Capacity to consent to care and treatment was routinely assessed on admission to the service and recorded in the care and treatment notes. Where a patient lacked the mental capacity to consent to treatment, the service completed referral documents for a Deprivation of Liberty Safeguards authorisation to the relevant local authority. At the time of the inspection, five patients were subject to authorised Deprivation of Liberty Safeguards. The social worker had oversight of the operation of Deprivation of Liberty Safeguards in the service, and liaised the local authority to ensure applications were progressed.

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- Staff understood the principles of the Mental Capacity Act. Staff supported patients to make decisions when they had the mental capacity to do so. The mental capacity of patients usually improved whilst they were at the service, so staff said they often waited until they could decide for themselves.
- Staff worked with patients to promote their understanding, for example they understood that information may have to be repeated because patients had memory problems. Patients told us that staff explained their care and treatment in terms that they could understand.
- Staff gave an example of a patient who was resistant to support with their personal hygiene and who lacked the mental capacity to make decisions about this. Staff worked with the patient's family to develop strategies to support the patient and deliver care in the least restrictive way.
- Care records showed that the staff team checked that patients had the mental capacity to manage their financial affairs. Staff liaised with the patient's family and other agencies as appropriate to ensure that the patient's finances were managed safely.

Are services for people with acquired brain injury caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

- Patients said that staff treated them with dignity and respect. Patients told us staff were kind and caring and listened to them and acted on their views. For example, a patient said that if they did not show up for lunch, the staff would check on them and would always save some food for them if they were asleep. We observed that staff were polite and friendly with patients.
- Staff had a good understanding of the patients they cared for and could talk about their rehabilitation needs and their likes and dislikes.

- However, patients said that staff did not always knock before entering patient bedrooms. We observed that a staff member did not knock before entering a bedroom during the inspection.

Involvement of patients

- Staff involved patients in planning their care and rehabilitation. Patients told us that staff took the time to explain the rehabilitation process to them. They said they fully understood the reasons for their therapy sessions and how practising their skills would assist their recovery.
- Staff told us that they received individual feedback every month by email, based on what patients have said about them. This covered what staff were doing well, and what could be improved.
- Occupational therapists and psychologists facilitated groups with patients and encouraged them to fill in engagement and satisfaction questionnaires about the service. These showed a high level of satisfaction with the service.
- An advocate visited the service to support patients. Patients were aware of the service and how to access it.
- Care and treatment records showed that the staff team kept in contact with families and carers and appropriately involved them in planning care and discharge from the service.

Are services for people with acquired brain injury responsive to people's needs?

(for example, to feedback?)

Good 

Access and discharge

Bed management

- Admissions and discharges were planned in conjunction with NHS England who commissioned the service. The average length of stay for patients discharged from the service in the twelve-month period to 19 July 2018 was 83 days.

Discharge and delayed transfers of care

Services for people with acquired brain injury

- At the time of this inspection, there was one patient who was awaiting transfer to another service. This was delayed because of their complex needs.
- Most patients returned to their own home. The service's occupational therapists routinely checked the discharge environment to clarify whether any aids or adaptations were needed. The service liaised with NHS England and the local authority to ensure that there were safe discharge plans in place.

The facilities promote recovery, comfort, dignity and confidentiality

- At a previous inspection, we found that staff discussed patient care in an area where they could be overheard. At this inspection, there had been improvement, handover meetings were now held in a room and could not be overheard. There were signs on display reminding staff to keep information confidential.
- Patients had their own bedrooms which they could personalise. Patients said they could keep their possessions safe and secure. Patients could use their own phones to make calls.
- The layout of the service was suitable for patients with acquired brain injury. There was a gym and patients could access a garden area. Patients told us the food was of good quality and they could access snacks and drinks at any time.

Patients' engagement with the wider community

- Patients told us that from Monday to Friday they had therapy sessions and there were also groups and meetings which they attended. Patients said they enjoyed outings to the park and places of interest.
- Although the provider had recently arranged for more activities to occur at the weekends, patients told us that they were still sometimes bored at weekends due to the relative lack of activities in comparison to Monday to Friday. However, on the weekend prior to this inspection staff had organised a barbecue for current and previous patients and their families. Patients said they had enjoyed it.

Meeting the needs of all people who use the service

- Staff could access interpreters when this was necessary to communicate with patients and their family members. Staff gave examples of them learning key

phrases in the patient's first language so they could encourage them with their rehabilitation programme. Staff could arrange for written information to be translated if required.

- Staff wrote care plans in an easy read format for patients. The speech and language therapists advised staff on how to communicate with patients and wrote information on this into care plans.
- The service was wheelchair accessible. Staff had training in equality and diversity. Staff met the diverse needs of patients. For example, they could explain how they would support a patient in relation to their religion. Patients told us that they could access appropriate diets, such as a vegetarian diet when required. Patients said the food was tasty. However, two patients said they found the food too salty.

Listening to and learning from concerns and complaints

- Patients knew how to make a complaint or raise concerns. In the 12 months up until 30 June 2018, patients had made six complaints. Complaints were investigated thoroughly and a written response was sent. In the same period ten compliments had been received about the service.
- Two of these complaints were about staff being noisy during the night. Managers told us they had reminded staff to talk quietly and to close doors quietly at night.

Are services for people with acquired brain injury well-led?

Good 

Leadership

- The leadership team had the required skills, knowledge and experience in the rehabilitation and care of patients with acquired brain injury. The leadership team included a consultant neuropsychiatrist and a head of therapy with extensive experience who had been in post for about two years. The Head of Nursing and Quality was responsible for ensuring the continual

Services for people with acquired brain injury

improvement of the services from a safety, quality and governance perspective. The hospital director has been the CQC registered manager of the service since December 2016.

- The leadership team has been successful in implementing changes at the service. Since the previous inspection, improvements have been made in relation to the storage of medicines and keeping patient confidentiality. The service has also taken appropriate action to comply with guidance on single sex accommodation. The leadership team recognised there were further improvements to be made in relation to record keeping and had recently recruited a practice development nurse.
- Patients and staff said the leadership team were very accessible and knew what was happening in the service. They said they could easily approach a manager to talk with them. Senior managers from the provider organisation had visited the service.

Vision and strategy

- All new staff attended a corporate induction which included information on the provider's vision and values. Staff could explain they worked in a way that reflected the provider's vision of 'nurturing the world one person at a time'. For example, they could explain how they aimed to understand the individual needs of each patient and develop plans to support them with their recovery.
- Staff understood the role and purpose of the service and how it operated within the care pathway of patients with acquired brain injury.

Culture

- Staff told us they felt respected, supported and valued by the leadership team and the provider. They said that leadership at the service had improved during the past year, and that they had confidence in the management to improve the service.
- Staff were proud of the service. They said the staff team worked well together and they could see that they were achieving positive results with patients.
- Staff knew about the whistleblowing procedures and were confident that they would be listened to if they raised a concern.

- Staff said there were good training opportunities at the service. Managers encouraged staff to train and progress in their careers. For example, a nurse told us how they were encouraged to take management training, which was paid for by the provider.

Governance

- The provider had a clear assurance framework of what must be discussed at ward and senior management level. This set out what should be included on the agenda of the monthly clinical governance meetings held at the service. The staff team reviewed the learning from complaints and incidents at these meetings.
- The leadership team had implemented recommendations from reports on incidents. For example, acting recommendations from an investigation report, the team had changed how staff checked the identity of visitors to patients.
- The provider had a framework for clinical audits. This stated the frequency of infection control audits, for example. Managers also undertook audits of care and treatment records. Managers had identified that care plan records required further improvement.
- The hospital director had easy access to information on the performance of the service. This included information on incidents, complaints and staffing. This information was reviewed by the Chief Executive and other senior managers at a monthly meeting.
- The service had an up to date risk register. This explained current risks in relation to staffing, the environment and equipment. There were action plans in place to manage risks. Staffing of the service was a recognised risk. Managers were using values based recruitment and new staff were due to join the service, significantly reducing the vacancy rate.
- Staff told us that they could obtain resources and equipment as required. For example, psychologists had made out the case for additional resources which resulted in an additional part-time psychology post for the service.

Information management

- Staff told us they had access to the information technology they needed to do their work.

Services for people with acquired brain injury

- The hospital manager had access to a dashboard on the performance of the service.
- The service made the appropriate notifications to the CQC.
- The service managers regularly met with the commissioners of the service. The service had good communication with the local adult safeguarding team.

Engagement

- The hospital director met monthly with the provider's senior management team and other hospital directors. This meeting discussed service development.
- Managers collected feedback from patients, carers and staff and used it to make improvements. Patients told us service managers asked for their views. They said they were listened to and changes were made in response to their feedback, for example to the menu. Staff said they could give their views about the service.
- Managers gave staff the time to carry out research to benefit patients. The consultant neuropsychiatrist had a visiting teaching contract with a local university for students who are taking their degree in clinical neuropsychiatry. This has led to systematic literature review and clinical audits into the prophylactic use of anti-epilepsy drugs in brain injury patients.

Learning, continuous improvement and innovation

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The service should continue work to improve care planning.
- Managers should continue to remind staff not to enter patient bedrooms without knocking first.
- The service should ensure that food is not too salty for some patients.