

Cygnet (OE) Limited

Cygnet Newham House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

We rated this service as good because:

- The service provided safe care. The hospital environment was safe and clean. The hospital had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The staff teams included or had access to the full range of specialists required to meet the needs of patients in the hospital. Staff worked well together as a multidisciplinary team and with those outside the hospital who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well-led and the governance processes ensured that procedures ran smoothly.

However:

- Not all staff had up to date appraisals in place in line with the providers policy.
- Staff had not clearly recorded details of one-to-one sessions between the patient and their named nurse.
- Staff had not updated all patient's medicine cards to reflect their current status (e.g. detention, informal or Deprivation of Liberty Safeguard).
- Staff did not ensure capacity assessments to treatment, for patients who were informal or on a Deprivation of Liberty Safeguard, contained the proposed treatment they were assessed for.
- Staff did not ensure capacity to treatment assessments for patients were easily available in the prescription folder.
- Staff had not reported all non-patient incidents such as administration issues which may affect the effective running of the hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Good 	



Summary of findings

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Summary of this inspection

Background to Cygnet Newham House

Cygnet Newham House is an independent specialist assessment and neurorehabilitation hospital provided by Cygnet (OE) Limited. The hospital, located in Middlesbrough, provides treatment for women over the age of 18 years who have experienced a brain injury after birth. It also offers those diagnosed with a progressive neurological disease like Huntington's Disease, a longer-term placement to support and help manage the progression of their symptoms.

The hospital consists of 12 hospital beds and 8 transitional care beds providing patients with a one care pathway through their rehabilitation.

The hospital is registered to carry out the following activities:

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

The hospital had a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated regulations about how the service is managed.

At the time of the inspection, there were 13 patients admitted to the hospital. Of these, five were detained under the Mental Health Act, five were subject to a Deprivation of Liberty Safeguard and three patients were admitted informally.

Cygnet Newham House was registered by the Care Quality Commission on 11 September 2020. This is the first comprehensive inspection since its registration. However, the hospital has been subject to a Mental Health Act monitoring visit since its registration. We took the findings of the Mental Health Act monitoring visit into account during this inspection.

What people who use the service say

During our inspection, we spoke with five patients and five relatives or carers.

Patients told us they felt safe in the hospital and that the staff looked after them well. They were able to go out and said that staff encouraged them to be involved in various activities. They liked the food and enjoyed having their hair, make up and nails done.

The feedback from all the relatives we spoke with was positive. They recognised improvements in the progress made in their family member's presentation. They felt the treatment provided was excellent. All relatives felt involved in decisions, they were invited to meetings about their family member, kept updated and were regularly asked for feedback. They told us staff were responsive, respectful and polite and felt they genuinely cared for the patients.

How we carried out this inspection

Our inspection team comprised one lead CQC inspector, a second CQC inspector, one specialist advisor and one expert by experience.

Summary of this inspection

This was an unannounced inspection.

During our inspection, we:

- Toured the care environment and observed how staff were caring for patients.
- Spoke with five patients who were using the service.
- Received feedback from five relatives of patients who were staying at the service.
- Spoke with the registered manager.
- Interviewed 12 other staff including the consultant psychiatrist, specialist doctor, qualified nurses, support workers, the Freedom to Speak Up Guardian, members of the multi-disciplinary team and auxiliary staff.
- Attended and observed a staff handover meeting, a patient's multidisciplinary meeting and a daily manager's meeting.
- Attended a patients' community meeting.
- Reviewed five care records.
- Completed a specific check of medicines management and reviewed all medication records.
- Reviewed a range of documents and policies in relation to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure staff appraisals are completed in a timely manner in line with the provider's policy.
- The service should ensure staff clearly record details of one-to-one sessions between the patient and their named nurse.
- The service should ensure that staff update all patient's medicine cards to reflect their current status.
- The service should ensure that capacity assessments to treatment, for patients who are informal or on a Deprivation of Liberty Safeguard, include the proposed treatment for which they are assessed.
- The service should ensure capacity to treatment assessments for patients are easily available.

The service should ensure staff are clear on what constitutes a recordable incident.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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 

We rated safe as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.

Managers carried out an annual ligature risk assessment. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. At the time of our inspection, there were no patients in the hospital at risk of ligaturing.

The hospital had blind spots meaning staff could not easily observe patients in all parts of the ward. Staff used regular observations as indicated in a patient's individual risk management plan to mitigate risks where this was required.

Staff had easy access to alarms and patients had easy access to nurse call systems. The hospital had CCTV in all patient areas.

Maintenance, cleanliness and infection control

The ward area was clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. They followed infection control policy, including handwashing.

There were appropriate COVID-19 guidelines in operation at the service. Hand sanitisers were available for patients, staff and visitors to use.

Services for people with acquired brain injury

Clinic room and equipment

The clinic room and treatment room were both fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. During the inspection, we observed that staff did not use an appropriate thermometer to monitor the clinic's room temperature. Staff were recording the temperature based on the air conditioner remote control reading. We informed staff while on the inspection and as a result an appropriate room thermometer was obtained specifically for the clinic room.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

The service had enough staff to keep patients safe. The hospital had two shifts per day covering 24 hours seven days a week. The minimum staffing requirements for each day shift were two registered nurses with four support workers. For night shifts this was one registered nurse with four support workers. The service had no nursing vacancies. There were four support worker vacancies at the time of our inspection which they were in the process of recruiting into. The hospital had recently recruited a neuropsychologist who was due to start the week following our inspection. There was a further vacancy for a psychology assistant.

The hospital used bank and agency staff to ensure minimum staffing levels were maintained. The service had reducing rates of bank and agency staff. New staff were due to start at the service in the weeks following our inspection. Managers predicted agency usage would be down to 5% by the end of September 2022. Agency staff that were used worked regularly at the hospital and were therefore familiar to patients and the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had a 38% turnover rate. This included bank staff who had not taken up shifts in a three-month period and were therefore out of date with their training.

Managers supported staff who needed time off for ill health. Levels of sickness were low at 2.7%

Managers accurately calculated and reviewed the number and grade of nurses and support workers for each shift. They could adjust staffing levels according to the needs of the patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

Services for people with acquired brain injury

The mandatory training programme was comprehensive and met the needs of patients and staff. Training included topics such as safety intervention, intermediate life support, basic life support, infection prevention control, equality and diversity, and information governance. Overall, 92% of staff had completed the providers mandatory training programme.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

The service used the Short-Term Assessment of Risk and Treatability (START). We reviewed five records relating to the care and treatment of patients. We found in all records staff had completed a risk assessment for each patient and those assessments had been regularly reviewed and updated.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to, or posed by, patients. Patient risks were discussed in staff handover meetings, in the daily managers meeting and in weekly ward rounds. The multidisciplinary team updated assessments, management plans and care plans with robust interventions to minimise or remove the risks.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Levels of restrictive interventions were mainly due to one patient requiring low level holds several times per day for staff to support personal care. Staff recorded these interventions as incidents. They were delivered in line with the patient's agreed care plan and with consideration of the patient's best interests.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. They understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed The National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff had used rapid tranquillisation on 20 occasions in the 12 months prior to our inspection.

The hospital did not have a seclusion room and there were no patients in long term segregation.

Services for people with acquired brain injury

Staff assessed patient's restrictions individually. For example, keys to open kitchen areas were dependent on a patient's risks. Managers carried out an audit of their restrictions annually to ensure they were not applying blanket restriction to the whole patient group.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Safeguarding training was included in the provider's mandatory training requirements. Ninety percent of staff had completed the required safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting safe. Children were not permitted onto the ward. Visits were facilitated in designated rooms outside the ward area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a safeguarding lead to support staff if needed.

Managers took part in serious case reviews and made changes based on the outcomes. They discussed safeguarding in governance meetings, team meetings, staff handovers and the manager's morning meeting.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. They reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The supplying pharmacy attended the hospital weekly to undertake medicine checks. The consultant psychiatrist reviewed patients' medicine charts on a weekly basis.

Staff received training on different levels of medicines management, appropriate for their role. Ninety percent of staff had completed their medicine management training units.

Services for people with acquired brain injury

Staff completed medicines records accurately. We reviewed all the patient's medicine records and mostly found evidence of good medicines management. However, some patient's medicine cards were not updated to reflect their current status such as their detention section. We found that capacity assessments to treatment, for patients who were informal or on a Deprivation of Liberty Safeguard did not contain the proposed treatment they were assessed for. Additionally, capacity to treatment assessments for three patients were not easily available in the prescription folder.

Staff stored and managed all medicines and prescribing documents safely. They followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff mostly recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff mostly knew what incidents to report and how to report them. They reported serious incidents clearly and in line with the provider's policy. However, during our inspection we were informed the hospital's printer had been out of action for over a week. This meant that staff needed to travel to another service to obtain paper templates for staff to record observations. The printer was reported for repair however, staff had not recorded this as an incident. This meant managers would not necessarily follow incident processes to learn lessons to reduce reoccurrence.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff were prompted by the electronic incident reporting system when duty of candour applied.

Managers debriefed and supported staff after any serious incident. Staff also attended a daily debrief at the end of their shift to reflect on what had gone well and what had been challenging. Staff debriefed patients when appropriate.

Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service. Lessons learnt were shared through local and regional bulletins and in team meetings. Managers discussed incidents at organisational level as part of the provider's clinical governance structure.

Services for people with acquired brain injury

Are Services for people with acquired brain injury effective?

Good 

We rated effective as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. They regularly reviewed and updated the care plans when patients' needs changed. However, staff had not clearly recorded details of one-to-one sessions between the patient and their named nurse.

Care plans were personalised, holistic and recovery orientated.

We reviewed the care plans of five patients during our inspection. All care plans were up to date, detailed and addressed a wide range of patients' needs including rehabilitation goals.

Staff used the views of family members to ensure they were individual to the patient. Family members felt involved in the planning of care for their relative.

Managers from the hospital audited care plans to ensure they met their need.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance. The service used an organisational model of care, focussing on assessment, stabilisation, rehabilitation and discharge. The model incorporated guidance from recognised bodies, such as, the British Society of Rehabilitation Medicine and the National Institute for Health and Care Excellence. All staff were trained in the model.

Services for people with acquired brain injury

Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists as required. The staff team included a registered general nurse who took the lead role in a patient's physical health. The hospital had a service level agreement with a local GP surgery. The GP attended the hospital twice weekly. Patients also had access to other specialists such as dentistry, podiatry, chiropody and optometry as needed.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. The service employed a speech and language therapist and a dietician who carried out assessments to identify a patient's eating and drinking difficulties.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff supported patients to the local gym and swimming pool. Patients regularly participated in walking groups and morning exercises. Smoking cessation support was available to those who needed it.

Staff supported patients to develop their everyday living skills. For example, patient schedules included options to help make their lunch, laundry tasks and room cleaning. Staff identified patients' skills and activities prior to their brain injury to engage them in activities. For example, one patient assisted staff in daily health and safety checks based on their previous career in security.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included The UK Functional Assessment measure, Model of Human Occupational Screening and Goal Attainment Scaling.

Staff used technology to support patients. This included access to computers, telephones and electronic tablets. The equipment helped to facilitate video calls with patient's friends and family, online shopping and online games.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. The provider had a schedule of audits that the service was required to undertake on an annual, quarterly or monthly basis.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a range of specialists to meet the needs of the patients on the ward. This included a consultant psychiatrist, speciality doctor, occupational therapists, a speech and language therapist, dietician, physiotherapist and general, mental health and learning disability nurses. At the time of our inspection, a full-time psychologist was not in post. Patients received psychology support remotely and when needed. However, a new psychologist was due to start the following week.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. They gave each new member of staff a full induction to the service before they started work.

Services for people with acquired brain injury

Managers supported staff through regular, constructive supervision of their work. The hospital used the provider's framework for supervision which had an expectation for staff to receive monthly supervisions. Staff at the hospital were 96% compliant in clinical supervision and 89% compliant in managerial supervision. Staff also had regular informal supervision and daily debrief sessions for group reflection.

However, managers did not support staff through regular, constructive appraisals of their work. The appraisal rate was 43%. Managers were aware that this was quite low and not many staff had had an appraisal. They had recently recruited a clinical lead and had an action plan to ensure staff appraisals were completed by the end of September 2022. All staff we spoke with felt supported and told us their performance and development were included in supervision conversations.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They made sure staff received any specialist training for their role. This included a neuropsychiatry workbook for all new staff including agency, and additional training sessions on autism, epilepsy, The International Dysphagia Diet Standardisation Initiative, neuro medicine, classification of head injuries and diabetes.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting and saw how staff from different disciplines worked together in a patient focussed way. Each member of the multidisciplinary team had input into patients' treatment and care plans.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The organisation provided various courses dependent on the staff member's role. Staff were above 90% compliant in all training units relating to the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who to contact when support was needed.

Services for people with acquired brain injury

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Advocacy attended the service regularly and was multi-disciplinary meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. They made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. They stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Routine audits included information to patients of their rights, consent to treatment and section 17 leave paperwork.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards and had a good understanding of the principles. They were over 90% compliant in the provider's training. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We found detailed mental capacity assessments for patients' decisions around physical health and finances.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Are Services for people with acquired brain injury caring?

Services for people with acquired brain injury

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it. We observed staff demonstrating positive interactions with patients. This included all staff members including housekeeping and maintenance staff. There were always staff present in communal areas to support patients.

Staff supported patients to understand and manage their own care treatment or condition. Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient. They felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments. There was evidence in records that staff found ways to communicate and involve patients in their treatment. All patients were invited to their multi-disciplinary meetings.

Staff involved patients in decisions about the service, when appropriate. Patients attended a daily morning meeting and a monthly communications meeting. The ward had a 'You said, We did' board, and minutes displayed from the meetings. Patients had previously contributed towards staff interviews. However, at the time of our inspection there were no appropriate patients to be involved.

Patients could give feedback on the service and their treatment and staff supported them to do this. The hospital encouraged and supported patients to participate in regular hospital surveys.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services. The advocate visited the ward every week and all patients were offered the opportunity to meet with them.

Services for people with acquired brain injury

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers and helped them to give feedback on the service. The organisation had a family and carer strategy aimed at ensuring family members were equal partners in their loved one's care. We spoke with five family members. All were positive about the care staff at the hospital provided. They felt involved in decisions and told us staff kept them regularly updated.

Staff gave carers information on how to find the carer's assessment.

Are Services for people with acquired brain injury responsive?

Good 

We rated responsive as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The hospital had been open since September 2020. Patients admitted to the hospital had an average length of stay of 220 days. The patient with the longest stay at the hospital was admitted in November 2020.

The hospital had 20 beds. At the time of our inspection, 12 patients were in the hospital and one patient was receiving treatment at the local acute hospital for physical health conditions. There was always a bed available when patients returned from leave. The service had low out-of-area placements. Staff considered referrals for patients outside their area due to the hospital's speciality. The multi-disciplinary team carried out assessments and discussed referrals in meetings to make sure the most appropriate patients were admitted. At the time of our inspection, patients were mainly from Yorkshire and the North East. This meant that relatives were within reasonable travel times.

Discharge and transfers of care

Patients did not have to stay in hospital when they were well enough to leave. Since opening in September 2020, the hospital had admitted 22 patients. Of these, nine had since been discharged.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We observed the records of five patients. All records contained clear discharge plans which staff regularly reviewed. Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Services for people with acquired brain injury

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. They had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to lounge areas, activity rooms, a beauty salon and a homely dining area. The hospital included two self-contained bungalows giving up to eight patients an opportunity to prepare for independent living. At the time of our inspection, two of the patients were staying on one of the bungalows.

The service had an outside space that patients could access easily.

The service had quiet areas and a room where patients could meet with visitors in private. They could use their own phones or the hospital phone in their rooms for private calls.

Patients could make their own hot drinks and snacks if able to do so. Staff supported those patients requiring assistance.

The service offered a variety of good quality food. The hospital employed a chef and a kitchen assistant cook who prepared all meals on site. Patients we spoke with told us they liked the food.

Patients had a weekly schedule of activities and therapies. These included cooking, art, mindfulness, singing and dancing and walking groups.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Patients had access to facilities so they could have virtual meetings with their loved ones and family members were encouraged to visit patients as often as they wanted.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. For example, staff supported one patient to maintain a relationship with her daughter by helping choose presents and aiding her to read books. Staff supported patients to visit and attend venues of interest to them. These included leisure centres and shopping areas.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Services for people with acquired brain injury

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital, including all bedrooms, were accessible to patients with mobility needs. They employed occupational therapists to assess patients who may need additional equipment. The ward area included clear signage and pictures for those with communication difficulties. Staff used pictorial tiles for some patients to support communication.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. They could obtain information leaflets available in different languages if required and had access to an interpreter service.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The cook was trained to The International Dysphagia Diet Standardisation Initiative (IDDSI) standards meaning they prepared meals to meet the needs of those individuals with dysphagia. They catered for both patients and staff with individual cultural requirements. The chef, speech and language therapist and dietician mostly attended the managers morning meetings to ensure each patient's individual dietary needs were accommodated.

Patients had access to spiritual, religious and cultural support. The hospital had a multi-faith room and staff supported patients to visit their individual places of worship.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Both formal and informal complaints were recorded. In the 12 months leading to our inspection, the hospital had received nine formal complaints, three of which were upheld and four partially upheld. Managers reviewed the complaints regularly to identify themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment because they welcomed the feedback to help improve care.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

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

We rated responsive as good.

Services for people with acquired brain injury

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The hospital had been open since September 2020. Patients admitted to the hospital had an average length of stay of 220 days. The patient with the longest stay at the hospital was admitted in November 2020.

The hospital had 20 beds. At the time of our inspection, 12 patients were in the hospital and one patient was receiving treatment at the local acute hospital for physical health conditions. There was always a bed available when patients returned from leave. The service had low out-of-area placements. Staff considered referrals for patients outside their area due to the hospital's speciality. The multi-disciplinary team carried out assessments and discussed referrals in meetings to make sure the most appropriate patients were admitted. At the time of our inspection, patients were mainly from Yorkshire and the North East. This meant that relatives were within reasonable travel times.

Discharge and transfers of care

Patients did not have to stay in hospital when they were well enough to leave. Since opening in September 2020, the hospital had admitted 28 patients. Of these, 15 had since been discharged.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We observed the records of five patients. All records contained clear discharge plans which staff regularly reviewed. Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. They had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to lounge areas, activity rooms, a beauty salon and a homely dining area. The hospital included two self-contained bungalows giving up to eight patients an opportunity to prepare for independent living. At the time of our inspection, two of the patients were staying on one of the bungalows.

The service had an outside space that patients could access easily.

The service had quiet areas and a room where patients could meet with visitors in private. They could use their own phones or the hospital phone in their rooms for private calls.

Patients could make their own hot drinks and snacks if able to do so. Staff supported those patients requiring assistance.

Services for people with acquired brain injury

The service offered a variety of good quality food. The hospital employed a chef and a kitchen assistant cook who prepared all meals on site. Patients we spoke with told us they liked the food.

Patients had a weekly schedule of activities and therapies. These included cooking, art, mindfulness, singing and dancing and walking groups.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Patients had access to facilities so they could have virtual meetings with their loved ones and family members were encouraged to visit patients as often as they wanted.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. For example, staff supported one patient to maintain a relationship with her daughter by helping choose presents and aiding her to read books. Staff supported patients to visit and attend venues of interest to them. These included leisure centres and shopping areas.

Meeting the needs of all people who use the service

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