

Royal Hospital for Neuro-Disability

Royal Hospital for Neuro-Disability

Quality Report

West Hill
Putney
London
SW15 3SW
Tel: 020 8780 4500
Website: www.rhn.org.uk

Date of inspection visit: 23-25 June and 8 July 2015.
Unannounced visits on 4 and 5 July 2015
Date of publication: 04/11/2015

This report describes our judgement of the quality of care at this hospital. 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Hospital for Neuro-disability is an independent medical charity which provides neurological services to the entire adult population of England.

The hospital specialises in the care and management of adults with a wide range of neurological problems including those with highly dependent and complex care needs, people in a minimally aware state, people with challenging behaviour and people needing mechanical ventilation.

Our key findings were as follows:

Safe

- There were sufficient staff but only with heavy reliance on agency nurses and healthcare assistants who were not trained in neuro-rehabilitation. Some nurses did not have the full range of competencies to work in all areas of the hospital, for example with tracheostomy patients.
- The hospital had many patients requiring long term assistance with breathing but did not have in-house medical expertise.
- The out-of-hour's system was not robust and a doctor was not always available when required.
- Incidents were reported and investigated but the electronic reporting system was new and there was as yet limited analysis of trends and little feedback to ward level.
- Staff had basic in-house training in adult safeguarding but no training at higher levels in the protection of vulnerable adults and their understanding of safeguarding was weak. Most staff were unaware of wider safeguarding issues such as risks of financial abuse.
- The environment was visibly clean and records demonstrated that equipment was maintained and checked regularly.
- Medicines were safely managed.
- Record keeping was inconsistent across different areas of the hospital, and for most patients very clinical. A unified and more holistic record keeping system had been introduced for new patients and was being rolled out for all patients.

Effective

- Consent and capacity of patients were not always considered for simple decisions and there was a danger that staff were using a blanket "lacks capacity" for most patients when each capacity assessment should be decision-specific.
- Staff showed a very limited awareness of their roles and responsibilities under the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards. In particular, they did not recognise that patients who might not be able to make a complex decision, may be able to make more straightforward decisions.
- Forty two patients at the hospital had the capacity to consent to treatment and seven were awaiting a capacity assessment. The remainder of patients either had authorisations in place in accordance with the Safeguards, were awaiting assessment by the Local Authority or had been assessed by the Local Authority but waiting for authorisation under the Safeguards.
- Staff made the assumption that they were working in a patient's best interests without the appropriate supporting documentation and there was limited documentation of the views of families being sought.
- Staff recognised the challenges in measuring the effectiveness of care and treatment of many of the patients, but had not developed other outcome measures. However, where guidelines for treating this group of patients existed, they were followed.
- Goal planning and risk assessments were good on the neuro-behavioural unit, but on other wards, goal planning was not always sufficiently individualised.

Caring

Summary of findings

- Most staff treated patients with dignity and respect. However, we also saw some staff that were very task-oriented and who spoke little to patients.
- There was room for improvement in care plans to give a more holistic view of patient needs.
- The hospital chaplain provided excellent support for patients, their families and staff.

Responsive

- Improvements in patient flow were needed as the hospital was an outlier for length of stay. This would shorten waiting lists.
- There were many complaints about the quality of food. The food choice was limited and the presentation poor. There was little account taken of individual preferences and we saw no Asian, Caribbean or African food.
- Patients had access to assistive communication technologies such as communicating using a computer and powered wheelchair controls.
- Patients had meal mats with their photograph and a visual guide to the placement of food and the appropriate diet.
- Religious needs were respected and patients could be taken to services in line with their faith.
- Many services, both clinical and leisure were provided on site which reduced the need for wheelchair users to travel and a range of leisure activities were available to long stay residents.
- For those living in the specialist nursing home, the environment was not sufficiently homely given that for many residents this was their home.
- Complaints were dealt with in a timely way, but we noticed that some issues tended to recur, indicating that long term solutions to concerns raised had not been found.

Well-led

- Significant changes in leadership, governance structure, senior staff and organisational culture had been made in the previous year, but yet to be embedded. The new leadership team was not yet well established and had a significant task ahead to embed the changes they were making.
- The duty of candour and the requirements of the Mental Capacity Act 2005 were not well understood by staff working at the hospital.
- There was still work to do to refine the unique specialisms of the hospital and its associated specialist nursing home; and to strengthen the culture of listening to patients, relatives and staff as well as to develop quality outcome measures that would demonstrate the impact the hospital staff were having on patients with profound disorders of consciousness.
- Staff supported the vision for the hospital to become a centre of excellence in acquired brain injury.
- A business transformation plan was in place. The prime focus for the year ahead was on achieving financial stability and developing the competencies of nursing staff.
- A patient representative committee and family peer support group was available for patients and relatives/carers.

We found the following area of practice to be outstanding:

- Eye-gaze technology was an innovative form of electronic assistive technology to help people with very limited or no physical movement, such as people with motor neurone disease or locked in syndrome, to communicate and make full use of computers. The hospital had successfully trained several of its patients to use this.

There were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure appropriate medical cover for all patients at all times, particularly for those who need long term assistance with breathing for whom there was no in-house medical expertise.
- Improve the understanding of all staff on the range of potential safeguarding concerns that can arise with this patient group.

Summary of findings

- Ensure that all staff comply with the Mental Capacity Act, 2005, with regards to consent, mental capacity assessments and Deprivation of Liberty Safeguards, including recording the detail of decision-making meetings about patients' mental capacity and best interests; and arrange for appropriate patients to have Independent Mental Capacity Advocates.
- Ensure that staff understand the legal requirements of the duty of candour in relation to being open and honest with patients and their families when things go wrong with care and treatment.

We found breaches of regulations in relation to the need for patient consent, the safe care and treatment and safeguarding service users from abuse and improper treatment. We have taken action against the provider and will report on this when our action is completed.

In addition the provider should

- Improve the coordination of medical care currently split between GPs and hospital doctors.
- Implement seven day therapeutic services for patients on the Brain Injury Unit.
- Involve families in decisions about Do Not Attempt Cardiopulmonary Resuscitation and End of Life care and ensure these conversations are documented.
- Improve the training and support for permanent and agency nurses and healthcare assistants including safeguarding, resuscitation and for nurses the full range of competences needed to care for all patient groups in the hospital.
- Improve the choice and presentation of the food provided.
- Individualise the goal planning for all patients in the hospital.
- Improve patient flow through the hospital by reducing the length of stay of appropriate patients.
- Where appropriate, make the environment for long stay patients more 'homely' in line with current expectations of facilities for residential accommodation.
- Actively encourage family involvement on all wards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Why have we given this rating?

The hospital had undergone a lot of change in the past year and many of the staff, as well as the processes and procedures were relatively new.

Safety was not a sufficient priority in all areas. Staff followed approved procedures to provide appropriate care and treatment to patients and there was adequate staffing. However, the high proportion of agency staff impacted on the continuity and standards of care offered. There was no in-house medical expertise for patients requiring assistance with breathing. Incident reporting was lower than expected for a hospital of this size.

Although staff were aware of the basic principles of safeguarding vulnerable adults, the training did not give sufficient emphasis to the specific vulnerability of patients with acquired brain injury.

Patients were cared for by multidisciplinary teams and standard measures were used to assess patients in the Brain Injury Unit and plan their rehabilitation. Although clinicians recognised the standard measures were not sufficiently accurate for such a specialist group of patients, they had not identified alternative measures to assess the outcomes of their rehabilitation interventions.

There were pockets of good practice by nursing and healthcare staff. The goal setting for patients with neuro-behavioural issues was one area and we saw some innovative work on technology to help people communicate. Work led by people with communication difficulties to provide bespoke training to staff in how individual patients communicated was also an area of good practice.

The environment for long stay patients was more clinical in appearance and atmosphere than nursing homes, i.e. they did not appear to be a homely environment. In some units, there were two or three residents in some of the bedrooms which raised the issue of privacy and dignity and did not meet modern day expectations of a suitable environment for residential care.

There was still work to do to refine the unique specialisms of the hospital and its associated specialist nursing home; and to strengthen the culture of listening to patients, relatives and staff. The board was confident

Summary of findings

that the hospital was moving in the right direction. The Board was not yet on top of important issues such as compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards, the duty of candour and the development of appropriate quality measurements for patient outcomes.

Royal Hospital for Neuro-Disability

Detailed findings

Services we looked at

Brain injury service, Specialist services and Specialist nursing home

Detailed findings

Contents

Detailed findings from this inspection

	Page
Background to Royal Hospital for Neuro-Disability	7
Our inspection team	7
How we carried out this inspection	7
Facts and data about Royal Hospital for Neuro-Disability	7
Areas for improvement	32
Action we have told the provider to take	33

Background to Royal Hospital for Neuro-Disability

The vast majority of the Royal Hospital for Neuro-disability work is commissioned by the NHS, either by NHS England (for Level 1 and Level 2a complexity) or by clinical commissioning groups (CCGs).

The hospital was originally the Putney Home for Incurables, established in the mid-19th century. It

remained independent in 1948 when most hospitals moved into the NHS. Most funding come from the NHS. Around 8% of the hospital's income comes from fundraising.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers

Inspection Manager: Roger James, Care Quality Commission

The hospital was visited by a team of 17 people including CQC inspectors, inspection managers, pharmacist

inspector and a variety of specialists. The team of specialists comprised of consultant anaesthetist, consultant neuro-psychiatrist, neurophysiology nurse, neuro-behavioural nurse, general practitioner, neuro-physiotherapist, mental health act reviewers and an expert by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, 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?

The inspection team inspected the following services:

- Brain injury service
- Specialist nursing home
- Specialist services

Detailed findings

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospital. These included the CCGs and NHS England.

We held interviews, focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested.

We spoke with patients and observed how they were being cared for. We also talked with carers and/or family members and reviewed patients' treatment records.

We carried out an announced inspection of Royal Hospital for Neuro-disability between 23 and 25 June and on 8 July 2015. We also undertook unannounced visits to the hospital on 4 and 5 July 2015.

Facts and data about Royal Hospital for Neuro-Disability

Context

- Royal Hospital for Neuro-disability is based in Putney, South West London and serves the entire population of England.
- The hospital offers three separate service areas for adults:
 - Brain Injury Service (BIS) for level 1 and 2a patients
 - Specialist Services. This covers services for ventilated patients, those with advanced Huntington's Disease and a unit for patients with challenging behaviour
 - Specialist nursing home for people with acquired brain injury requiring long term, 24 hour nursing care

Activity

- The hospital has 227 beds; 49 Brain injury beds, 55 specialist services beds and 123 specialist nursing home beds.
- The hospital employed 449.6 WTE staff at May 2015. The workforce is supported by a significant number of temporary bank and agency nursing and healthcare assistant staff, who cover staffing shortfalls.
- There were 468 referrals to the hospital during 2014
- There were 26 patient deaths at the hospital between January and December 2014.

Inspection history

This is the first comprehensive inspection of Royal Hospital for Neuro-disability.

Medical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Royal Hospital for Neuro-Disability is an independent medical charity that provides rehabilitation and long term care to adults over 18 years of age with complex neuro-disabilities. People are referred from many different parts of England and almost all of the 227 beds are commissioned by the NHS, either by NHS England or Clinical Commissioning Groups. At the time of inspection the age range of patients was 19 to 70 years.

The hospital is divided into three separate departments; a brain injury service, specialist services and a specialist nursing home. The brain injury service provides rehabilitation to up to 49 people at any one time, in three wards. There are two pathways: one for rehabilitation and one for prolonged disorders of consciousness (PDOC). Clifton and Devonshire wards care for patients with PDOC. Drapers ward (20 beds) provides rehabilitation and disability management planning for people with severe acquired brain injury. All are Level 1-2a services commissioned by NHS England.

The specialist services unit has five wards with 53 beds in total. Coombs and Wolfson Wards have 24 beds for people with advanced Huntington's disease. Wellesley Ward is a 13 bed unit for people with challenging behaviour and Jack Emerson ward has 16 beds for patients requiring mechanical ventilation because of neurological disease or an accident. The beds on these wards are purchased by clinical commissioning groups.

The specialist nursing home wards has 125 beds for people with profound and complex disabilities that require long term 24 hour nursing care. The patient who has been resident on the unit the longest has been there for 40 years. The six wards are graded broadly according to the level of

awareness of patients: The wards are Glynn, Andrew Reed, Cathcart, Hunter, Chatsworth and Evitt Wards. Evitt Ward is mainly for younger people who are disabled, between 18-40 years.

There is a small community unit for the disability management of people, who attend on a day care basis. The capacity of the unit is up to 10 patients. We spoke to 28 patients/family members and at least 50 staff at all levels and from many disciplines and looked at about 25 sets of patient notes. We ran focus groups for different groups of staff and had interviews with senior managers and clinical staff and spoke to about 20 volunteers.

Medical care

Summary of findings

The hospital had undergone a lot of change in the past year and many of the staff, as well as the processes and procedures were relatively new.

Safety was not a sufficient priority in all areas. Staff followed approved procedures to provide appropriate care and treatment to patients and there was adequate staffing. However, the high proportion of agency staff impacted on the continuity and standards of care offered. Nurses and therapists did not have the full range of competences related to enteral feeding and tracheostomy, or working with patients who required assistance with their breathing so they could work on any ward. The combination of day time GP cover with out of hours cover provided by hospital doctors did not provide a well-integrated medical experience to all patients. There was an example of two different doctors giving different diagnoses on the same day. The hospital pharmacy had no involvement in GP prescribing. The hospital did not have onsite medical expertise on ventilated patients.

Incident reporting was lower than expected for a hospital with this number of patients.

Although staff were aware of the basic principles of safeguarding vulnerable adults, the training did not give sufficient emphasis to the specific vulnerability of patients with acquired brain injury. Most staff were unaware of wider safeguarding issues such as risks of financial abuse. More advanced training was required on safeguarding, on meeting the requirements of the Mental Capacity Act 2005 and on deprivation of liberty safeguards (DoLS) to meet the needs of patients in vulnerable circumstances who needed support with most aspects of daily life. Medicines were managed safely.

Patients were cared for by multidisciplinary teams and standard measures were used to assess patients in the Brain Injury Unit and plan their rehabilitation. Although clinicians recognised the standard measures were not sufficiently accurate for such a specialist group of patients, they had not identified alternative measures to assess the outcomes of their rehabilitation interventions.

There were pockets of good practice by nursing and healthcare staff. The goal setting for patients with neuro-behavioural issues was one area, and we saw some innovative work on technology to help people communicate. Work led by people with communication difficulties to provide bespoke training to staff in how individual patients communicated was also an area of good practice.

In relation to the specialist and long term nursing care services, there was confusion among staff over whether the environment was a hospital or a care home with nursing. Descriptors such as 'ward' and 'unit', 'patient' and 'resident' were frequently mixed up during conversations with staff. The environment for long stay patients was more clinical in appearance and atmosphere than nursing homes, i.e. they did not appear to be a homely environment. In some wards, there were two or three patients in some of the bedrooms which raised the issue of privacy and dignity and did not meet modern day expectations of residential care.

There was still work to do to refine the unique specialisms of the hospital and its associated specialist nursing home; and to strengthen the culture of listening to patients, relatives and staff. Although the board was confident that the hospital was moving in the right direction, there was a significant amount of work to do over a long period if the hospital were to become a national leader for this group of patients. The Board was not yet on top of important issues such as compliance with the Mental Capacity Act, aspects of safeguarding, the duty of candour and the development of appropriate quality measures for patient outcomes.

Medical care

Are medical care services safe?

Safety was not a sufficient priority. There were insufficient permanent staff and a heavy reliance on agency nurses and healthcare assistants. Few nurses were trained in neuro-rehabilitation. Medical cover shared between hospital doctors and GPs for long term residents was not sufficiently coordinated and there was limited access to medical care out of hours. Not enough nursing staff or therapists had the full range of competences to work everywhere in the hospital.

Incidents were reported and investigated but the electronic reporting system was new and there was as yet limited analysis of trends and little feedback to ward level.

The environment was visibly clean and records showed that equipment was maintained and checked regularly. Medicines were safely managed. Record keeping was inconsistent across different areas of the hospital and key decisions were not always documented in sufficient detail. A new unified patient record was being introduced for new patients and was being rolled out across the hospital.

Staff had only basic training in safeguarding vulnerable adults, which did not make clear the range of vulnerabilities of patients with acquired brain injury and how to protect people from abuse. Most staff were unaware of wider safeguarding issues such as risks of financial abuse.

There were insufficient staff trained in advanced life support and despite the inclusion of the use of a defibrillator in basic life support training, not all staff we spoke with knew how to use a defibrillator.

The major incident plan had been recently revised but the plan was not yet widely available to staff and the plans seen on wards were very out of date and not fit for purpose were there to be an emergency.

Incidents

- There had been one serious incident and 11 statutory notifications of serious injury between January and December 2014.
- Clinical incidents were discussed monthly at mortality and morbidity meetings which therapists and nurses were encouraged to attend. This committee also reviewed reports from the coroner. Meeting minutes

were available and actions were assigned to individuals for completion and detailed root cause analyses were carried out where service issues were identified. This committee reported to the Patient Safety and Quality (PS&Q) Committee which met every two months.

- Clinical staff had developed a mortality review tool to review unexpected deaths in a common format. The documentation we reviewed enabled cases to be reviewed in a consistent way across the hospital.
- Fewer incidents were reported than would be expected for either a hospital or care home with nursing of its size. An electronic incident reporting system had recently been introduced and not all staff had yet been trained. The previous paper based system had not enabled easy analysis of incidents, but managers were confident the new system would allow analysis of trends in incidents in a more timely way. The mechanism for spreading learning to ward level required further development and senior managers recognised this.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- Notice boards on the wards gave figures for the previous month's record on urinary tract infections, pressure ulcers, clostridium difficile and methicillin resistant staphylococcus aureus (MRSA) and falls. Venous thromboembolism (VTE) assessments were carried out on patients in the brain injury service. These were known as quality measures.
- During 2014 there had been 47 cases of pressure sores, 55 falls and 33 urinary tract infections.
- Monthly returns of healthcare associated infections were submitted to Public Health England through the Association of Independent Healthcare Providers. There had been no PHE reported infections in 2014. However, there was no formal and active system for notification of pathology results. Staff told us that it could take a month to obtain results.

Cleanliness, infection control and hygiene

- Cleanliness was monitored through spot checks and an annual hygiene audit. Spot checks enabled corrective action to be taken quickly if required. The last audit was completed at the end of 2014. The audit was benchmarked on the Infection Prevention Quality Improvement Tools – Care setting process Improvement Tool: Inpatient/ Care Home (Infection Prevention Society, 2010) and the results were satisfactory except for waste segregation. Ward managers were informed of

Medical care

the waste segregation issues and actions were required to be implemented and monitored accordingly. We saw cleaning in progress on wards. Appropriate warning signs were displayed and the cleaners were wearing personal protective equipment such as disposable gloves and protective aprons. We did not see problems with waste segregation during our inspection.

- Ward managers nominated staff members to be infection control link nurses and all new starters received infection control training.
- A few patients had been identified as carriers of MRSA, but there had been no infection since 2008. A chrysanthemum sign on the door of such patients' rooms indicated the need to use personal protective equipment, when giving personal care. We observed staff washing their hands or cleaning them with antiseptic gel, and using gloves and aprons in appropriate circumstances.
- There had been no clostridium difficile infection outbreak since 2010, when there had been four infections in the hospital.
- Patients returning from acute hospitals following admission, were screened for MRSA within 24 hours of their return. Swabs were sent to a local trust and results came back through the GP.
- There were no designated isolation rooms, but staff told us that if necessary a patient in shared rooms could be moved into single rooms for infection control reasons.
- There was a segregated laundry system for any infected persons, which used a red sack system.
- Routine water testing had shown high levels of pseudomonas (a common bacterium) in 12 shower outlets during June 2015. Appropriate precautions were being taken to ensure that patients with elevated risks of infection were not showered in the affected showers and that sterile water was used to clean stoma sites, wounds and tracheostomy tubes. Staff monitored the residual risk from this and a number of wards were now clear from pseudomonas.
- Equipment cleaning audits were not carried out. We noted sporadic use of 'green clinically clean' stickers and in one case, we saw items with green stickers stored in a dirty utility room.

Environment and equipment

- The wards and public areas were clean and well maintained.

- There were sufficient hoists and these and other patient care items were clean and ready for use. Some wards had ceiling track hoists but it had not been possible to install these in all parts of the hospital. This was because the main building was listed as of historic importance and there were restrictions on internal alterations that would affect the character of the building.
- Electrical equipment was serviced and in good repair. Some items had several stickers showing different dates of portable appliance testing. This was poor practice.
- Resuscitation equipment was available and defibrillators had been serviced and records showed they had been checked regularly.

Medicines

- Medicines were stored securely on all wards. Controlled drugs (CDs) were stored in suitable cupboards and records were maintained. A recent controlled drugs audit had highlighted some minor issues which had been addressed.
- Patients' allergies were recorded on the prescriptions, medication administration records and in medical notes. These were updated as needed and we saw that medical staff referred to this when prescribing.
- Prescriptions and medication administration records were clear and records were made of medicines administered or codes used to record why a medicine had been omitted. We noted that if nurses had failed to document the necessary medicine records, it was reported and action taken was to address the reasons why this was the case. Staff on medication rounds wore a red apron to indicate that they should not be disturbed. This was intended to reduce medication errors, but as it had been only recently introduced, it was too early to judge the impact.
- The hospital adhered to an antibiotic policy developed with a local NHS hospital which had been reviewed in February 2015.
- Pharmacists visited all the wards regularly and visited more frequently the areas which had more medicine changes. We noted that pharmacists were part of the multidisciplinary team and were involved in decisions about prescribing and medicine use. Interventions were recorded and acted upon, and learning passed down to the ward team.

Medical care

- Medical and nursing staff were informed of drug alerts and patient safety information in a timely way and could describe to us how this information was made available to them.
- Nurses told us that they received annual safe handling of medication training and annual competency reviews but we did not see records to confirm this. We observed medicines being administered in a safe and caring manner.
- Some wards stored emergency medicines and equipment behind locked doors to which not all staff had access. This could cause delays in treating people in an emergency.
- On all wards, records demonstrated that staff checked the temperatures of medication fridges and storage rooms daily. These were within recommended limits. However, these temperatures were checked first thing in the morning and we noted that the rooms increased in temperature during the day. Some medicines, particularly nutritional supplements, must be stored between 5-25°C, so more frequent monitoring would ensure their safety. During warm weather, we noted that on two wards, air conditioners were being used to keep drugs and artificial nutritional supplements cool.
- Resuscitation drugs were in date and in sealed containers. However, some staff said they were unsure of how to use defibrillators even though this was included as part of mandatory basic life support training. This presented a risk to some patients, particularly out of hours.
- There was currently no designated resuscitation officer to arrange training and to ensure there was always a staff member on site with these skills. There was no intermediate life support training offered to staff. We noted that a number of clinical staff were registered for advanced life support training as there were only four doctors qualified at this level. No nurses held advanced life support certificates although some were booked on training later in the year. at this level. This was not in line with national guidance that there should be someone with advanced life support skills on every shift.

Records

- Until March 2015, patient records had been very clinically orientated and not kept in the same format on every ward. This was being addressed throughout the hospital by the introduction of new standardised care

plans which focused on individualised care, looking at a person in a more holistic way and taking account of social and recreational needs, family relationships as well as clinical needs.

- Records were stored securely but there was no standardisation between wards on where they were stored.
- Records were predominantly handwritten on paper. Not all interactions with patients were routinely documented and dates and times were not always clear. Therapeutic activities and treatment goals were not always evident in records we looked at. On one set of notes where there were no physiotherapy notes for a week, no reason had been provided.
- While clinical records of patients in the nursing home service were of a satisfactory standard and well-ordered, care plans were only updated every three months, whereas best practice would indicate reviewing and updating care plans and Waterlow scores of all patients at least monthly.
- For patients with behaviour that challenges the service, we did not see frequent reviews of risks and goals. Where risk scores were held on computer, such as in the Wellesley ward, no risk information had been transferred to the main paper record so nursing and care staff did not have easy access to this information. These records did not consistently show how pre-admission risks had been recorded and used in care plans.

Safeguarding

- Staff were aware of the more extreme incidents that would raise a safeguarding concern and the process for reporting these. For example, pressure sores of grade three and above were reported as safeguarding concerns. However, wards did not consistently display information on about safeguarding processes and the understanding of some staff on the range of potential safeguarding concerns was weak.
- There were fewer safeguarding referrals than might be expected from this kind of service. There had been 12 safeguarding incidents investigated during 2014, and five safeguarding incidents within the first six months of 2015. The threshold for reporting safeguarding incidents seemed low and ward staff we spoke to were not aware of action plans from safeguarding investigations was disseminated to ward level.

Medical care

- The provider had a safeguarding procedure to follow when a referral was made, however, staff only had very basic training in recognising abuse and ways of reducing the likelihood of abuse such as enabling people to make choices and have their preferences respected. Most staff were unaware of wider safeguarding issues such as risks of financial abuse. The need for more safeguarding training was recognised by senior staff.

Security

- Security was contracted out and was predominantly concerned with security of the site including the grounds.
- In the unit for people with challenging behaviour patient, control and restraint was managed by clinical staff appropriately trained in managing violence and aggression. Security staff were not involved.
- Wards kept a register for visitors, for fire and security purposes. There were plans under consideration for passes for regular visitors.
- On one ward, we saw a lock code displayed on a noticeboard, which presented a risk of unauthorised use.

Mandatory training

- Staff told us that new staff undertook two weeks mandatory induction and that 98% of new had completed this, but we did not see records to corroborate this.
- Annual training was arranged to take place on two separate days a year: Study Day 1 and Study Day 2. The content of the second day depended on staff's roles. Some training was face to face, such as manual handling, and some was through e-learning, for example for waste management, food hygiene and incident reporting. Attendance and bookings for mandatory training in the current training year from January 2015 was about 67% against a target of 95%. Basic life support was part of mandatory training. In 2014 96% of staff had completed mandatory training.
- Although deprivation of liberty safeguards (DoLS) and the Mental Capacity Act, 2005, were included within mandatory training the time allowed for this was insufficient. Only one hour was given to this in the annual update training.
- The practice of neuro-rehabilitation was not part of mandatory training for nurses, contrary to the recommendation of the Independent Rehabilitation Providers Alliance.

Assessing and responding to patient risk

- Staff told us that until recently they had not had sufficient controls to ensure that patients were medically stable on admission to the brain injury service. Some medical problems were outside the scope of the hospital's capability as it was not an acute hospital.
- To avoid inappropriate admissions to this hospital, staff had revised their structured assessment and screening procedures, and in some cases staff visited patients being considered for admission. Staff used the Patient Categorisation Tool agreed with NHS England for Level 1 and 2a service providers. A doctor commented that whereas patients used to be admitted six months after the onset of their brain injury, increasingly they were being transferred earlier from acute hospitals and their medical conditions were therefore sometimes less stable. Managers told us that the hospital was under pressure to admit more patients with tracheostomies. They currently capped the numbers at 50 patients to align with the number of nurses currently trained to manage patients with tracheostomy in order to manage such patients safely.
- The hospital did not use the national early warning scores (NEWS) to monitor patients' vital signs and trigger escalation. However, clinical staff did use the Stability of the Vital Signs Scale (SVSS).
- We saw little evidence of the involvement of relatives in the risk assessment of patients or that relatives themselves had been helped to understand risks such as knowing how to give physical support to their loved one in a safe way.

Nursing staffing

- Overall we considered that staffing levels protected people from avoidable harm. However some wards, particularly the ventilator unit were not optimally staffed. More staff would enable a more timely response to alarms on that unit. Operational managers reviewed staffing levels in relation to acuity weekly, although ward managers told us they could request additional staff on a shift if necessary.
- Managers had reviewed and revised safe staffing levels twice in the past year. Three modern matrons had been appointed to support the new staffing structure and also to encourage staff to move from task-oriented to

Medical care

more holistic care. This was intended to strengthen nurse leadership which had been recognised by the executive team as a weakness in the past. It was too early to judge the effectiveness of this change.

- Ward staffing budgets covered leave, sickness, mandatory training and professional development, but there were insufficient permanent staff, and a heavy reliance on agency staff. Some doctors, nurses and other healthcare staff, as well as some patients and relatives, expressed concerns about the competencies of some of the agency staff. Managers were aware of these concerns and seeking to address them.
- The staffing establishment was displayed on each ward, but we did not see this changed when there were fewer staff on a given day. Ward managers monitored staffing on a day by day basis. They did not report low staffing levels as incidents. One ward had extra staff at particular times of day or night to cover more labour intensive periods, which seemed to work well.
- Several staff, as well as managers were keen to reduce the proportion of agency staff, because of the impact this had on the continuity and standards of care delivered.
- The process for inducting agency staff varied according to the ward and the individual nurse in charge. We saw a clear but lengthy set of guidance on the ventilator unit, but no system to show which staff had read it. We were not aware of any incidents that had resulted from staff not reading guidance.
- The management were developing a bank of permanent staff to limit the reliance on agency staff and had amended payment for bank work to make it more attractive to existing staff. This would provide better continuity of care to patients.
- We observed nurse handovers on five wards. Not all relevant staff were present for the start of handover, nor were patients who might need additional care prominently highlighted. There was no typed handover sheet so nurses took handwritten notes. Care staff did not generally take notes at all. Some relevant information for the handover was handwritten in a diary on wards; however we observed an instance when incoming staff struggled to read the handwriting.
- Nurses were not required to administer intravenous drugs. If a patient was judged to require intravenous (IV) antibiotics or re-hydration, they were transferred to an acute hospital. Managers were considering using a community nursing service called 'Healthcare at Home'

for some patients in the nursing home who might need IV antibiotics or fluids. Patients in the Brain Injury Unit were sometimes less medically stable and they were more likely to need transfer to hospital if they became more unwell. During the 18 months from January 2014 168 patients had needed to be transferred to an acute hospital. A number of these had been transferred on multiple occasions. The number of patients transferred had been rising year on year. Transfers were for medical management beyond the scope of the hospital or for emergencies including where cardiology intervention was required.

- There were specialist nurses covering continence and tissue viability. The hospital no longer had a specialist tracheostomy nurse to give appropriate advice to staff, however we were told following the inspection that there was a tracheostomy multi-disciplinary clinic, with input from a doctor, speech and language therapist, physiotherapist and a specialist Intensive care consultant nurse (from an external organisation), which met fortnightly.
- Nurses were sometimes rotated to other wards and one nurse during our inspection was asked to work in a ward where they believed they did not have the right skills to work, and had had to argue against the move. The fact that nurses did not have the competences to work in every ward could present a risk to patients on days of staff shortage.

Medical staffing

- The hospital was advertising for a medical director. There were three permanent consultants. A respiratory consultant from a nearby trust visited the ventilator unit fortnightly to give advice. We considered that a hospital with so many patients needing long term assistance with breathing, should have in-house medical expertise.
- An end of life consultant visited monthly and a sessional consultant neurologist had oversight of the long term care of patients with Huntington's disease.
- The lead for the neuro-behavioural unit was a rehabilitation physician as there was no lead psychiatrist.
- Eight specialty physicians were ward-based. There was no resident doctor and a rota of doctors on-call covered all patients in the hospital out-of-hours and at

Medical care

weekends. We observed that the out-of-hour's system was not robust and a doctor was not always available when required. This was a risk to patients in an emergency.

- A GP service covered the routine medical needs of patients in the nursing home. The hospital had a contract with an external GP surgery that provided two GPs in daily clinics, however the GP service operated independently of the hospital. Some clinics were held by the contracted GP, but most were covered by locum doctors. The GP service held records of 150 patients. There was no GP on-call service out-of-hours.
- Ninety seven per cent of patients registered with the GP were also under the care of consultants who held their own medical records for these patients. There were therefore parallel sets of medical notes. The combination of medical care from GPs and hospital doctors did not appear to be well-coordinated and the hospital pharmacy had no involvement in GP prescribing. We also saw an example of two different doctors giving different diagnoses on the same day.
- The neuro-behavioural unit was led by a neuro-psychologist.
- Part-time medical trainees from a nearby medical school came to learn about the rehabilitation process, particularly for patients in 'low awareness' states.
- Specialty doctors told us meetings had become more inclusive in the past few months and they were now more often asked for their views. They reported good support from consultants.
- Specialist Nursing Home: Following a request to the provider for further information after the inspection, we were told medical care to the specialist nursing home was provided by GPs, Monday to Friday 9am to 5pm. A consultant in palliative care medicine provided specialist medical input. The Huntington Disease wards (Coombs and Wolfson) received medical input from GPs with support from a consultant neurologist for specialist input. A rehabilitation consultant provided care and management to patients with spasticity.
- Brain Injury Services: Following a request to the provider for further information after the inspection, we were told there were six full-time specialty doctors and four full-time consultants in rehabilitation medicine who provided specialist medical care to patients in the brain injury services.

- Neuro-behavioural Unit: Following a request to the provider for further information after the inspection, we were told a consultant in neuro-rehabilitation and a specialty doctor provided medical care.
- Ventilator Unit (Jack Emmerson): Following a request to the provider for further information after the inspection, we were told routine medical input was provided by one consultant and two specialty doctors who had experience in respiratory medicine and neuro-rehabilitation. A respiratory consultant provided specialist input and saw patients every two weeks.
- The consultant in palliative care medicine provided specialist medical input for patients in the brain injury services, ventilator unit and neuro-behavioural unit if needed.
- We were told following the inspection that out-of-hours, there was an on-call doctor (consultant or specialty doctor) who attended to patients when called.

Therapy staff

- There were 29.19 whole time equivalent physiotherapists and over thirty other allied health professionals. These staff included clinical psychologists, clinical neuro-psychologists, dieticians, speech and language therapists, and occupational therapists. There were 18 vacancies.
- We were told that therapy staffing levels were generally based on the British Society of Rehabilitation Medicine Guidelines (BSRM) Standards for rehabilitation services, mapped onto the National Service Framework for long-term conditions (2009). Staffing levels in the Brain Injury Service were reviewed annually as part of the contracting process. A mix of qualified and unqualified support staff was used.
- There had been a high turnover of therapists and locums were used to cover leave and other absences. There were about 20 whole time equivalent unqualified therapists who ran some individual sessions and group work under the direction and supervision from a qualified therapist.
- Many therapists did not experience working in the ventilator unit so it was unclear how staff maintained their respiratory competencies or had opportunities to extend other rehabilitation skills. Limited transferable skills of staff could impact on service delivery when other staff left the hospital.

Medical care

- All therapy staff had been co-located within the hospital for the past six months. Although this had been a significant cultural change, staff said it had improved communication, peer supervision and there were now more joint assessments.

Major incident awareness and training

- Managers had recently reviewed and updated the major incident plan, although the revised plan had not yet been signed off by the Board. Staff on the wards were not aware of the new plan. We saw folders on wards purporting to be about emergency arrangements, but which contained a very out of date policy and no ward-specific instructions about emergency response.
- Evacuation practice was carried out as a table-top exercise which was acceptable given the group of patients. We noted from the risk register that some wards did not have evacuation stewards. In addition, agency staff on some wards did not know about evacuation plans.
- The new major incident policy also contained business continuity plans for various eventualities.

Are medical care services effective?

Patients were not always asked for consent and given choices. The hospital had few authorisations for Deprivation of Liberty Safeguards in place and applied a simplistic model of capacity that was not in line with the Mental Capacity Act, 2005 (MCA): i.e. not graded by the types of decision a person could make nor recognising the fluctuating cognitive powers of some brain injured patients. Most staff showed a very limited awareness of their roles and responsibilities under the MCA and DoLS. There was an assumption that staff were working in a patient's best interests without appropriate supporting documentation and there was limited documentation of the views of families being sought or taken into account.

There were challenges in measuring the effectiveness of care and treatment of many of the patients, because the standard data, particularly for assessing patients with disorders of consciousness were not sufficiently accurate for such a specialist group of patients. Clinical staff had not developed other methods to assess progress of patients or the effectiveness of their rehabilitation interventions.

Where guidelines for treating this group of patients existed, they were followed.

The focus on mandatory training meant that there had been less emphasis on developing nurses skills in areas such as skin care (tissue viability), tracheostomy and working with patients who required assistance with their breathing. We noted that as part of the new focus on recruitment and retention there were likely to be more training opportunities.

Goal planning and risk assessments were good on the neuro-behavioural unit, although they would benefit from greater patient and family voice in the goals.

On the long term care wards, goal planning was not sufficiently individualised

Evidence-based care and treatment

- For the brain injury service, the hospital provided monthly data to the UK Rehabilitation Collaborative (UKROC) which analysed data from all specialist level 1 and 2 rehabilitation units to inform rehabilitation requirements, the inputs required to meet them and the outcomes and cost benefits of rehabilitation for patients with different levels of need.
- The UKROC data indicated that for motor gains and cognitive gain during stay, the RHND results were below the whole group, although it did have a higher complexity rating than two thirds of the providers. This pointed to the number of patients admitted that may not have rehabilitation gains or low rehabilitation gains because they had such profound disturbances of consciousness. This group, as well as some other patients with acquired brain injury, may never recover from their illnesses. There was evidence that staff at RHND had considered these results, but not yet identified ways to change practice to address the variance or improve the flow through the Brain Injury Service.
- The standard UKROC measures of the benefit and effectiveness of therapy input were not very informative for this patient group. The Functional Independence Measure (FIM) and the Functional Assessment Measure (FAM) were used on admission and discharge, but were considered not sufficiently accurate for such a specialised group of patients. It was important to demonstrate that therapeutic interventions had an impact beyond natural improvements over time. It was unclear how staff were using the UKROC data to change practice.

Medical care

- Doctors and therapists were seeking to develop outcome measures that better reflected the neuro-behaviour of patients at the hospital. Areas being explored were to benchmark the following: successful weaning from tracheostomy tubes, management of bodily functions, sitting tolerance and family experience including support for families in dealing with loss and grief. We felt that urgent progress was needed here.
- A Music Therapy Assessment Tool for Awareness of Disorders of Consciousness (MATADOC) had been developed by staff at RHND which it was hoped could have greater sensitivity for detecting awareness in patients with disorders of consciousness. .
- The commissioning of 180 days of treatment for patients with prolonged disorders of consciousness had led to many patients being admitted to the Brain Injury Unit for a fixed period of time rather than a period focused on specific goals which would allow for individuals changing at different rates and therefore requiring different lengths of intervention.
- The Sensory Modality Assessment and Rehabilitation Technique (SMART), is a detailed assessment and treatment tool developed to detect awareness, functional and communicative capacity in patients with prolonged disorder of consciousness and the minimally conscious state. It was used in line with good practice. However, the goals set for patients were not always in language to which the family (whose presence is important to assessment and diagnosis) could easily relate.
- The management of spasticity using botulinum toxin was in line with national guidelines.
- End of life policies were based Royal College guidelines 2013, Prolonged Disorder of Consciousness National Guidelines. Palliative care was a part of the hospital's remit because for almost all patients, their injuries were degenerative and life limiting. Palliative care for this group of patients was not just about looking after people at the end of their lives. Staff were aware of the challenges of managing the expectations of families and managing the patients' treatment.
- There was no outreach service once patients left the Brain Injury Service or other contact with the hospital to assess the impact of rehabilitation interventions at the hospital in the longer term.
- Specific monthly research afternoons were intended to ensure services continued to develop against an evidence-base.
- A number of audits were carried out, though sometimes these were only on a single ward rather than hospital-wide.
- End of life care was medically led. An individual plan of care was agreed, including food and drink, symptom control and psychological, social and spiritual support. Some staff had been trained by a local specialist palliative care provider to help them support people effectively as they neared the end of their lives. All patients in the specialist nursing home had long term degenerative conditions and many patients would end their lives there.

Pain relief

- Most patients' notes contained a reference to medication when required for pain (commonly known as PRN - 'pro re nata'). Nurses said they were able to tell when a patient was in pain, even though most patients could not verbally express their needs.

Is design and decoration helpful in meeting individual needs

- The environment was more like a hospital than a home. Although some patients had some items in their rooms to reflect their individuality and a smaller number had their own furniture, the accommodation for most patients, including those in the specialised nursing home and long term specialist care, was clinical.
- Some patients had rooms with a view of the grounds. There were gardens attached to two wards that provided calming environments.
- Some wards had snooze rooms with multi-sensory lighting, fish tanks and bubble tube. However, one such room was also used for wheelchair storage and staff said they would move wheelchairs to the shower if the room was to be used.
- Some parts of the hospital offered a less restful experience. For example, on the ventilation unit, there was a high noise level from four different alarms day and night (ventilator alarms, patient call bells, pulse oximeters, as well as the door buzzer and telephones. The volume of these were not turned down at night, so there was no respite from the noise levels for patients. This was uncomfortable to conscious patients and

Medical care

conversely, minimally aware patients should not be overstimulated, so this was a poor environment for all patients. The noise was worse at night because there were fewer staff to respond to alarms, call bells etc.

- Patients on Wellesley Ward did not have easy access to outdoor space.
- On one ward at a weekend, we saw a sign to help patients orientate themselves that purported to display the date and the weather. However, the date displayed was the date two days previously and the weather was displayed as sunny when it was raining.

Nutrition and hydration

- Patients nutritional and hydration needs were monitored by dieticians. However, patients' swallowing ability was not automatically reviewed each year which meant there could be delays in detecting impaired swallowing problems, which were common in this patient group and could present a risk to patients.
- The Brain Injury Service had local targets set by commissioners to ensure patients' weight goals were achieved.
- A high proportion of residents received their nutrition artificially through percutaneous endoscopic gastronomy (PEG) tubes. These patients had a review of their nutrition every three to six months in line with NICE guidance CG32.
- Patients were weighed monthly or more frequently if there were concerns about weight loss or gain.

Patient outcomes

- The full Patient Categorisation Tool (PCAT) to confirm category A or B needs was used before admission and on discharge. The Neurological/Trauma Impairment Set was also used.
- We saw from the UKROC data on the Brain Injury Service patients (49 beds) that 40% were admitted with tracheostomy (a tube inserted in the windpipe to help them breathe). Half of these patients had their tracheostomy tube removed before they were discharged. Benchmarking of the Brain Injury Service against the NHS England Service Specification was being undertaken.
- Ninety-nine percent of patients admitted required specialist wheelchair prescription and specialist seating was provided promptly.

- Only 15% of patients admitted to the Brain Injury Service returned home. The remainder moved into specialist nursing homes.
- Drapers Ward displayed rehabilitation outcomes on the ward; such as where they were discharged to, tracheostomy weaning and achievement of oral feeding as well as their outcomes on the FIM-FAM measures of function and the Extended Rehabilitation Complexity Scale.
- The Northwick Park Nursing Dependency Scale (NPDS) and the Extended Rehab Complexity Scale were completed fortnightly. Other measures used were the Wessex Head Injury Matrix, Tracheostomy Therapy Outcome measures and the Sensory Modality Assessment and Rehabilitation Technique (SMART) as well as goal attainment scales.
- The specialist nursing home used the Extended Rehab Complexity Scale twice a year and the Health of the Nation Outcome Scale for acquired brain injury on a quarterly basis.
- The Neuro-rehabilitation Unit took part in the Independent Rehabilitation Providers Alliance Study.
- The hospital did not formally offer slow-stream rehabilitation. The nursing home service provided maintenance therapy to manage patients' physical disability and management of spasticity and prevention of contractures as well as regular re-positioning to prevent pressure sores. However, some family members said they would have liked to see more personalised controlled stimulation and encouragement for interaction, and ongoing monitoring of their level of responsiveness.

Competent staff

- We saw training calendars on display in the office with forthcoming training. New staff were assigned a mentor and a healthcare assistant (HCA) buddy worked with them for a week while they were supernumerary.
- There was preceptorship programme for newly qualified nurses. Nurses completed the development of competences over a year rather than the usual six months, but no one could explain why the system had been set up that way or what additional benefit there might be. We noted that the same preceptorship training pack was being used for new overseas trained staff without any assessment of whether this provided appropriate support for this group of nurses.

Medical care

- Some nursing staff said they were supervised monthly and received an individual performance review which was reviewed at six monthly intervals. However, practice was not consistent across wards and staff on other wards said they had no supervision. Appraisal rates overall were 34% for nurses and 29% for healthcare assistants.
- Relevant nursing staff had assessments on medication administration, tracheostomy, gastrostomy, blood glucose, venepuncture and ventilation. We saw that three regular agency staff had completed the assessments.
- Various training sessions were held at lunchtime on wards. In response to splint audits that had revealed lax practice, lunch time training sessions had been held for HCAs on splinting people who had or were at risk of shortening of the muscles or joints. Staff who had attended said it had increased their confidence in carrying out splinting.
- Although we met a few staff doing higher levels of training (for example MSc studies), staff said the recent focus had been on mandatory training and there were few opportunities for professional development.
- Therapists had a good supervision structure and access to training related to staff's objectives. Records showed that 57% of therapy staff had appraisals.
- There was no specialist training, for example in tracheostomy or palliative care offered to the locum GPs providing medical services to the nursing home patients.

Multidisciplinary working

- There was good multi-disciplinary (MDT) working on the wards for brain injury patients and the specialist services. Members of the MDT called in daily on most wards. Weekly therapist meetings were separate from the medical meetings. Goals were set, with involvement of families in some cases but not all. All families should be involved as much as possible. Milestones were monitored at MDT case reviews. However, ward managers could not show us consistent evidence of MDT meetings taking place.
- Patients had access to psychologists where appropriate.
- Physiotherapy for long term care patients in the specialist nursing home was not sufficiently tailored to

individual needs. There was limited facility for patients to return for repeated episodes of rehabilitation. Therapists said this was mainly because of the difficulty with arranging funding.

Seven-day services

- There were no seven day therapeutic services for patients on the Brain Injury Unit. However, we were told following the inspection that the hospital does meet the requirements set out in British Society of Rehabilitation Medicine (BSRM) Standards for rehabilitation services, mapped onto the National Service Framework for Long-Term Conditions. ISBN Number: 978-0-9540879-8-2. BSRM, London 2009.
- We were told that patients were seen by physiotherapists four or five days a week. No physiotherapists came in at weekends nor were they on-call. This was out of line with National Quality Board Standards for Acute Medical Units which set good practice as physiotherapy being available from 11am to 8pm seven days a week. There were also no speech therapists available to see patients at weekends. Neither was there an overnight on-call rota for respiratory physiotherapy. This was not sufficient to optimise the rehabilitation of patients on that unit.
- X-rays and diagnostic ultrasound were available on site two days a week. Outside these times, patients had to be taken to an acute hospital. We did not have evidence that this was detrimental to the care of long term patients.
- We were told that doctors came in for two hours each day at the weekend. The doctor who came in would email medical colleagues about any issues. There was no consultant presence at the weekend.
- The nurse who was the bleep holder at the weekend or at night had a high level of responsibility given the number of patients. There was a risk to patients if several became unwell.

Access to information

- Information for staff was mainly in paper form. Ward receptionists printed out emails or policy changes for ward staff to read. We did not see many ward staff using computers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were disappointed with the level of understanding and application of the Mental Capacity Act, 2005,

Medical care

bearing in mind the vulnerability of the patient group. Some training in the Mental Capacity Act had been carried out recently but the level of understanding among ward staff was low. Consent and capacity of patients were not always considered for simple decisions and there was a danger that staff were using a blanket “lacks capacity” for most patients when each capacity assessment should be decision-specific. However, following a request to the provider after the inspection, we were provided with forms which indicated that some patients had decision-specific mental capacity assessments carried out.

- During the inspection, there was little evidence of practice that was consistent with the legal requirement of the Mental Capacity Act in decisions about medication and treatment and lack of understanding among doctors and nurses about the challenges of assessing the capacity of an individual with acquired brain injury.
- We observed that many nurses who had worked at the hospital a long time understood some of their patients' needs and wishes well and responded to these effectively, even though they might not be familiar with the details of the MCA.
- Staff considered that over 75% of patients lacked the capacity to consent to medical treatment. However, the hospital had accumulated a backlog of applications for DoLS because for some time, there had been no senior manager responsible for Mental Capacity Act issues. A short term appointment had been made in May 2015. Although applications had been made for relevant patients, only 59 standard authorisations had been authorised at the time of our inspection. While requests for the remaining 175 patients were still outstanding because of delays in obtaining local authority responses. Local authorities have 21 days to complete standard authorisations. Managers did not have not a robust central system for expediting these, or for dealing with renewals which will fall due every year for these patients. While authorisations were outstanding deprivation of liberty was not authorised. Staff did not seem fully aware of the legal implications of this, that care plans required amending to ensure the person could be supported in a less restricted way. Nevertheless, we were told by the provider following the inspection that there were 77 patients in the hospital who were subject to DoLS and 90 DoLS applications outstanding.

- We were unable to find very much evidence of patients or their relatives' views about care and treatment recorded in care plans. However, some families we spoke with said they had been involved in discussions about their relative's care.
- Few patients had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders on their files. We were told that families were reluctant to agree these on behalf of their relatives because to do so seemed to them like giving up hope. There was no documentation on patient's notes to indicate that discussions about DNACPR took place routinely for all patients or that DNACPR decisions were reviewed quarterly in line with the hospital's stated policy.
- It was difficult to find detailed records with evidence of best interest decision making or written minutes from best interest decision making meetings in patients' files. This was out of line with the recommendations of the Prolonged Disorders of Consciousness National Clinical Guidelines (2013). These guidelines also recommended use of a best interest's checklist based on the holistic balance of likely success, benefits and risks and harms. Good practice would suggest using an Independent Mental Capacity Advocate (IMCA), in any best interest decisions when a person had no family.
- We saw that that the hospital policy allowed patients to be given medicines covertly when administration was judged necessary in accordance with the Mental Capacity Act 2005, and the capacity of the patient to make decisions about their medication had been assessed, and after a best interests meeting had been held. This policy, which was appropriately drafted, was not always followed. One person receiving medicines in this way did not have either documentation of an assessment of their capacity to make this decision or a best interest meeting. Their care plan did not support staff to give medicines covertly. NICE guidance SC1 on having a documented process for the covert administration of medicines for adults was therefore not being followed.
- We were told that an audit of consent had been done but did not see this.
- Given the sudden nature of their brain injuries, very few patients (7) had given another person valid and active Lasting Powers of Attorney (LPA) for their finances and only one had given an LPA for Health and Welfare. All patients for whom DoLS authorisations were given would need a person appointed with legal powers to

Medical care

represent them. We found little evidence of the use of people with formal roles in decision making about a person such as an IMCA, or a person assigned with Lasting Power of Attorney (LPA) in relation to welfare, or a court appointed Deputy (health and welfare) to support best interest decisions. We were told that 27 patients had a deputy appointed by the court of protection.

- In specific cases where there is no one else available to consult about the person's best interests, an IMCA must be appointed to support and represent the person (MCA Code of Practice). However, the IMCA provider thought referrals were low because many had family and friends to support them and also because of patients' long length of stay.
- The use of advocates to guide patients and their families through the care pathway was recommended by the 'Rehabilitation following acquired brain injury: national clinical guidelines' (2003). Involvement of advocates might also help take pressure of families who found decisions about a patient's best interests difficult and provide protection for patients whose families might not always act in their relative's best interests.
- Staff said there had only been one intervention by the courts for withdrawal of clinically assisted nutrition and hydration when there was no prospect of recovery and continuation of treatment was not in a patient's best interest. Responsibility for initiating this would rest with the clinician treating the patient.
- Only one patient had an advance decision to refuse treatment that may or will affect how the hospital cares for them.
- The hospital was not registered to detain patients under the Mental Health Act 1983. We saw that urgent authorisations for DoLS had been made for some patients in the neuro-behavioural unit which was appropriate.
- We saw more than one instance where patients who had capacity to make decisions about care and treatment were allowed to make such decisions even if they might seem unwise, for example someone assessed as having a risk of choking choosing not to eat pureed food, and a patient choosing not to have dental treatment. Patient wishes were therefore being respected.

Are medical care services caring?

Staff treated patients with dignity and respect, and overall the feel of the hospital is of caring and well-meaning staff that genuinely cared for patients. However, we also saw some staff, particularly some agency staff were very task-oriented and spoke little to patients.

There was room for improvement in care plans to give a more holistic view of patient needs. We were aware that the hospital was rolling out a programme for improving care plans as well as working on greater involvement of families.

The hospital's annual independent survey of patients and relatives had the potential to drive change in the quality of care. The friends and family test showed a high proportion of families were likely or very likely to recommend the Brain Injury service.

The chaplain provided excellent support for patients, their families and staff.

Compassionate care

- We saw many care staff and nurses interacting in a kind and cheerful manner with patients, and some positive interaction that was caring and respectful. For example knocking on a door before entering a room and explaining what they were about to do. Some staff were seen to spend time communicating with patients with understanding of that patient's specific communication methods. However, we also observed some other interactions that were very task-oriented, where staff did not take time to listen to patients' needs. We observed staff chatting together rather than to patients. In these instances people were not always treated with dignity and respect.
- Some residents mentioned that nurses from agencies did not always treat them well, and could be 'rough' in moving people, many of whom required careful positioning because of their conditions..
- The standard of physical hygiene of patients was good and met the NICE Quality Standard 10 in respect of Personal hygiene and other physical needs.
- The chaplain was universally acclaimed by everyone we spoke with, staff, volunteers, families and patients, for his exceptional compassionate care, visiting all patients

Medical care

regularly; reading or chatting to them. Volunteers were also seen to provide care and support but other staff were seen to have little social engagement with patients.

- The friends and family test results were used for the families of patients discharged from the Brain Injury Service only. This was part of the contractual requirement. An example of a month in which there had been a number of discharges was in August 2014 where, of patients discharged, 88% of families responding to the test said they were likely or very likely to recommend the Brain Injury service. However, these results should be seen in context, as completion of the test was voluntary and the number of discharges since the test had been introduced were low.

Understanding and involvement of patients and those close to them

- Families were invited to visit the hospital before a relative was admitted to the Brain Injury Service and to meet senior staff.
- For the other long term services, family visits were also arranged. Families could also attend the annual review with funding agencies.
- We looked at 20 care plans. We noted that care plans were not generally written in the first person, and some were in professional language which did not reflect the patient or family voice. Many entries were task oriented, for example, they contained functional information such as photographs of appropriate positioning of the limbs, and pillows of each person to maximise their comfort. There was no expectation of patients or their advocates signing care plans routinely or that all patients for whom this might be possible were supported to understand their treatment (NICE QS5).
- The passport “All about me” was a potentially helpful tool to inform carers about aspects of person’s needs, including their communication needs. The document was not complete in itself as sometimes, entries referred the reader to ‘see notes’ rather than include a summary.
- It was not clear how changes in the person’s needs or care plan were communicated to staff. For example, we saw references in care plans for the need to reassess aspects of care with no documented evidence of follow up.
- We saw some examples of families being involved in personal care or attending physiotherapy sessions with

their relative. However, family involvement did not seem to be actively encouraged on all wards. Families of people more recently admitted seemed to be less happy with care.

- The hospital carried out an annual patient survey across the whole hospital. 89% of respondents said they were likely or very likely to recommend the hospital to their family and friends. Top concerns had been the quality of food, side effects of medicines and lack of individualised care. We saw that there were plans in place to address these concerns.
- Both volunteers and therapists mentioned that ward staff did not always get patients ready in time for their appointments, both medical and social. This meant some patients did not attend all the events they would like to attend. Therapists told us they were working more closely with nursing staff to ensure that patients did not miss therapy sessions.
- One patient mentioned that there had been communication problems with some overseas nurses whose English some patients found hard to understand, and who did not understand the patient's communication methods. This was frustrating for the patient. This was not in line with Best Practice in the NICE Quality Statement 2 about competence in communication skills.
- We saw televisions on for long periods during the day. The choice of programme in a communal area was by the patients most able to communicate. In general, we had the impression that patients who could speak for themselves or had vocal relatives possibly received more tailored care than other patients who were less able to make themselves heard.
- There were complex issues that relatives needed to understand and we were not sure that all relatives were well informed by staff.
- Relatives of patients in the specialist nursing home in particular said they did not have the opportunity to see doctors very often and felt that doctors expectations of patients was low.

Emotional support

- We did not see documented evidence of regular assessment of the emotional needs of those in the specialist nursing home.

Medical care

- However, where staff knew patients well, we saw appropriate emotional support, for example we saw one distressed patient who was being calmed by the nurse caring for them. It was clear that the nurse knew what would calm the person.
- The chaplain offered support to those without faith in one to one sessions for both patients and their families.

Are medical care services responsive?

The delivery of the Brain Injury Service was largely determined by the requirements of commissioners. Waiting lists for admission to this service was affected because the hospital was an outlier for length of stay of patients.

There was a mixed picture on how responsive the hospital was to patient's needs. Individually tailored care and support, the quality and presentation of the food, responsiveness to cultural and emotional needs and lack of private spaces were areas of concern. Conversely, patients with complex communication needs used electronic assistive technology such as eye-gaze equipment and switch access systems in order to improve their communication with staff. Eye-gaze equipment was a key communication aid known as alternative and augmentative communication and was innovative.

Many services, both clinical and leisure were provided on site which was helpful in reducing the need for wheelchair users to travel. A range of leisure activities was available to long stay residents who were able to benefit from these.

The volunteer service was good and liked by patients and families, but seemed often to be seen by staff as replacing social engagement of staff with patients. Interpreting services could be arranged as required.

The complex needs of most patients who required a high degree of care inevitably posed some restrictions on the choices of long term patients about when to get up, or shower or to go to bed when they chose. More choice could be offered here. We noted that some wards took on additional staff to help in the mornings and evenings which had the potential to respond to patient choice. For patients in the specialist services and the nursing home, the environment was not sufficiently homely given that for most residents this was their lifelong home.

Complaints were dealt with in a timely way but we noticed that some of the same issues tended to recur indicating that long term solutions to concerns raised had not been found.

Service planning and delivery to meet the needs of people

- The Brain Injury Service was a national service and followed commissioner's guidelines. The hospital worked closely with NHS England in this area. Likewise, in another specialist area, the hospital took advice from the Huntingdon's Disease Association in planning for those patients.
- A number of facilities were provided on-site to enable easy access for people in wheelchairs. There was a dentist in a specially adapted dental surgery, a podiatry service, a GP surgery, a hairdresser and provision of massage were also available at a modest price. Staff were considering bringing other clinical services on site such as a dermatology clinic and swallowing assessment clinic.
- Some wards dealt with busy times by bringing in additional staff. For example, both morning and evening on Chatsworth Ward, there were additional staff for a two hour period to help get patients up and put them to bed.
- Some services offered outreach to the local community, seating posture and muscle tone management, music therapy and assistive augmented communication services.
- Many care plans showed little recognition of the needs of patients with acquired brain injury for emotional support, despite the fact that all patients had suffered catastrophic, life changing events. Plans did not reflect patients' spiritual and emotional needs when faced with trauma and ill health, and how these needs could inform care strategies and risk assessments.

Access and flow

- During 2014, 468 referrals were made to the hospital. The number of actual admissions was much less because many had associated medical conditions that made them unsuitable, sometimes the patient's condition changed and some potential patients were admitted to other services in London or elsewhere. The brain injury service met the 10 day target from referral to assessment. However, this service did not always meet the 42 day target from assessment to admissions. The

Medical care

average time from assessment to admission was 47 days at the hospital. The recently appointed brain injury service coordinator had face to face contact with about 35% of referred patients but aimed to increase this to 65%.

- Improvements in flow were needed as the hospital was an outlier for length of stay. There were 23 patients on the waiting list for the Brain Injury Service in May 2015. A shared waiting list with other providers enabled some of those on the waiting list to find a placement more quickly if there was no immediate prospect of a place at RHND. The brain injury service coordinator was helping the service ensure that referrals to RHND were appropriate. Among rehabilitation patients, discharge plans began to be made on admission, although on our inspection, nine patients were still on these wards beyond the end of their allocated rehabilitation time awaiting placements.
- Social workers were employed to coordinate care from admission to discharge and make arrangements for the onward placement. They also supported families in coming to terms with brain injury in a relative.
- Very few long term residents were discharged back into the community. There had only been one or two in the past three years.

Meeting people's individual needs

- Residents could choose the gender of care assistants offering personal care. We were given the example of a patient of the Muslim faith whose husband did not want her to have male carers. A female resident with capacity had also chosen to have two female carers. Both of these choices had been respected.
- The RHND charity funded occupational therapy, art and music therapy and recreational activities such as a bathing pool for aqua leisure. We were told there was a visiting therapeutic dog (PAT dog) which stands for Pets as Therapy. Fish tanks in some of the lounges in the nursing home wards provided another means of relaxation for patients. We were told that one person on Evitt Ward liked to watch fish being fed and we witnessed this happening on one day.
- We saw some easy read communications such as meal mats, a guide to the Mental Capacity Act (seen on one ward) and guidance on raising concerns.
- Staff in Devonshire Ward (BIS) had some capacity to tailor a patient's day around visitors so that the patient would rest in the morning if a visitor was due in the afternoon.
- However we heard from patients and their families in the specialist nursing home that most people could not choose when they were showered, when they got up in the morning or the time they went to bed.
- Where patients had their own rooms, they were personalised, to varying degrees with family photos, collages and televisions. However, many patients were in shared rooms in both the hospital wards and long term nursing home, and personalisation was then more limited. The hospital planned in the medium term to have more single rooms in the younger person's ward to meet this group's expectation of greater privacy.
- None of the single or shared rooms had en suite facilities, so patients had to be wheeled to shower facilities on trolleys which limited their dignity, even though they were covered up.
- Patients did not have their names or photos on the doors of their rooms, even though many doors displayed the named nurse and key worker names. This added to the clinical feel of wards.
- Staff needed some prompting when asked about patients' cultural needs. Provision for this seemed to be the responsibility of individual families who bought flags or other cultural items for the relatives' rooms. Interpreters were used when patients and families did not speak English.
- There was less therapy available for long stay patients in the specialist services and specialist nursing home. Although some of these patients required maintenance therapy only, other patients could be considered to be on a path of slow-stream rehabilitation and might benefit from greater therapy input. A service evaluation was being undertaken to look at developing appropriate packages for rehabilitation on the basis that patients were being admitted earlier post-injury than in the past. Some staff and relatives felt this service needed to respond better to patient needs.
- The hospital was running a project designed to improve communication between staff and patients with complex communication needs who had good cognitive function but significant and complex disabilities. The patients used non-verbal communication systems such as partnered letter, chart systems (low tech) and/or the

Medical care

use of electronic assistive technology such as eye gaze (an eye operated communication) and switch access systems (which could be operated through one push switch, for example to control a computer for communication). This would result in bespoke individualised training to help educate and support staff caring for individuals who were dependent on specific communication technologies.

- The hospital had on-site facilities for specialised seating systems to maximise patients' interaction with others, and for a few offering the ability to move independently around the premises using powered wheelchair controls.
- Patients had access to assistive communication technologies such as through using a computer and powered wheelchair controls. Compass, the Assistive and Rehabilitation Technology Service at the hospital had been commissioned by NHS England to provide an Augmentative and Alternative Communication Service for West London.
- For patients who could feed themselves or be supported to eat, the food was not always appetising. We saw catering comments books on each ward, with a number of comments indicating dissatisfaction such as; 'Dry', 'Pasta not cooked' and 'Lasagne was like soup'. The hospital scored below average on Patient Led Assessments of the Care Environment (PLACE) assessments in relation to food, scoring 90 when the average score was 93. Forty percent of patients taking part in a survey considered the food to be fair or poor.
- The menu rotated on a three week cycle and there were two choices of main dish for lunch and supper. For vegetarians, there was no choice from the main menu. Meals had to be chosen three days ahead and some people told us they did not always receive what they had ordered. We were told there was an off-menu selection of jacket potatoes and beans on toast but this appeared not to be actively promoted. Those who benefited from this menu were those whose relatives were active in supporting meal choices. We observed mealtimes on three wards and had no concerns about how meals were conducted in terms of dignity. Some patients said they preferred not eat with other people as they felt less hurried if they ate alone.
- There was little account taken of individual preferences and we saw no Asian, Caribbean or African food. Patients who might like a cultural choice of meals had it bought in by relatives and we observed instances of this.
- Patients had meal mats with their photograph and a visual guide to the placement of food and the appropriate diet, e.g. mashed or pureed to help ensure that people had the correct meals. This was helpful to staff and some patients liked this.
- We saw some clearly written information for patients and families on Drapers Ward about the ward, ward routines and types of rehabilitation offered.
- Patients were informed about hospital policy on patient information such as 'Right to see records', which included how communication was managed from the hospital, as well as why and with whom information was shared.
- We noted some patients in shared rooms did not have a TV or music player which limited their opportunities for entertainment. Some of these individuals also had very little opportunity to be alone. When relatives visited, people in shared rooms had no private space on the ward.
- Some families mentioned noise on the wards at night which interrupted patients' sleep. This was mentioned in relation to Glynn and Jack Emerson Wards.
- Although we saw some informative documents about prolonged disorders of consciousness on a noticeboard in the training area, we did not see similar information on wards or more public areas.
- Religious needs were respected and patients could be taken to services in line with their faith and we saw volunteers take patients to church on Sunday morning.
- A high proportion of long term residents attended the weekly non-denominational service and there was also provision for Muslim prayer facilities.
- Welcome packs were sent out to new patients' families, including a questionnaire to find out more about the person's past life and interests.
- Some 160 volunteers supported a range of activities for patients. Some offered 1-1 activities, particularly to people who had fewer visitors. For example, they helped some residents to access Facebook, e-mails and the internet, or watch movies on an iPad. One volunteer came to sing to a patient who enjoyed song. Interdenominational religious services were held in the main building twice a week and volunteers took people who wished to attend.
- The leisure and family support service worked with volunteers to enable people to take part in group

Medical care

activities and outings. There was an active Boccia team (a sport designed for athletes with severe impairments) and they played other teams. We were told some “residents are very excited about this.”

- There were also some ward-based activities, although some residents said there used to be more such activities in the past such as; bingo, painting, wheelchair dancing and games.
- The ground floor of the main building had wide corridors and spacious, clean and well maintained public rooms enabling space for music and film clubs, as well as for families to come together in groups without being too close to others. This freedom was not possible on the wards unless patients had private rooms. The viewing area was an attempt to create an open area family room.
- However, the wards generally were not conducive to modern expectations of people and their families where there is an expectation of private rooms. Even though most three bedded bays showed evidence of patients being supported to create a personalised micro-environment, there was nonetheless an ‘institutional’ rather than homely atmosphere.
- There were two gymnasiums, an art therapy room, computer room and a hydrotherapy pool for water-based therapy and also for recreation, known as ‘aquability’. There were also some large public rooms where social events and concerts could be held.
- Spacious grounds meant that relatives and volunteers could take patients there and two wards had attractive small gardens which patients assisted in maintaining.
- Many patients were put to bed very early. Although for some patients this was because of limitations on their sitting tolerance, we were aware that other patients would have welcomed more choice about bedtime.
- The coffee bar was liked by patients and relatives.
- In the older parts of the building, temperature control was not very responsive.
- There was a lack of room for wheelchair storage, as many rooms were not big enough to accommodate patient’s wheelchairs. This meant that wheelchairs were lined up in corridors, in larger rooms on the wards and sometimes in shower rooms.
- Patients were allocated a named nurse as a primary point of contact for a patient and their relatives/carers. This allocation had been made following a patient/relative survey which showed that few patients knew who was responsible for their care. However, the

hospital did not provide patients with a named nurse for the current nursing shift, in line with the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients.

- Key workers, who were allocated to a patient on admission, had an overview of a patient’s care and offered a weekly phone call to families to report on progress. They also provided clinical support to social workers.
- A patient experience officer had been appointed in April 2014 to work with patients and relatives to improve communication channels within the wards. The information provided to patients and relatives at time of admission had been reviewed and rewritten to help better inform relatives and referring hospitals. A monthly family support group had also been set up.

Learning from complaints and concerns

- The hospital tried to resolve concerns through discussion. A review of complaints during 2014 had shown there were four times more informal complaints than formal complaints. There were 140 formal and informal complaints during 2014. Two thirds of the 34 formal complaints were substantiated. A third had been about nursing care. Analysis of complaints was being used to improve quality by understanding better the issues and action required. An example of a change made in response to a complaint about poor communication with patients and families had been to start a quarterly newsletter to inform relatives about changes within the hospital and events that were taking place. The first edition had been distributed in August 2014.
- All complaints were investigated and where appropriate action was taken and recorded, in line with the policy. The complaints policy did not mention the duty of candour. Written responses to formal complaints had been given within 28 working days during 2014 but this had now been reduced to 20 working days.
- We saw complaints leaflets in holders on the walls of some wards entitled, “Who do I talk to if...” Some relatives we spoke with said they felt uncomfortable about raising complaints, especially if they had raised a one before, but others said managers seemed more ready to listen than in the past.
- One parent who visited regularly told us they felt they often had to complain to staff about a variety of “small issues”. For example, they said “If clothes were not

Medical care

smoothed, this caused skin redness (to the patient), so I always smooth; staff don't. Ninety percent of the time staff do not do things properly. When my relative first came here I was quiet and accepted things but now I speak up. Every time I visit I have to complain."

- A patient representative group was chaired by a trustee and at a recent meeting had discussed food quality, clothes missing when sent to the laundry, and staffing. One outcome from these meetings had been the provision of more physiotherapy, although relatives said this had taken a long time to achieve. Relatives said that there had improvements in transparency and openness from management.

Are medical care services well-led?

After significant changes in the previous year in the governance structure, in senior staff and in the organisational culture, the board and the executive team staff were seeking to achieve a period of stability to allow the changes to become established.

There was still work to do to refine the unique specialisms of the hospital and its associated specialist nursing home; and to strengthen the culture of listening to patients, relatives and staff. There was a significant amount of work required over a long period to meet the objectives of becoming a national leader for this group of patients. The board was not yet on top of important issues such as consent, compliance with the Mental Capacity Act, the duty of candour and developing appropriate quality measurements for patient outcomes.

Staff supported the vision for the hospital to become a centre of excellence in acquired brain injury, including its research function.. A business transformation plan was in place. Financial stability and developing the competences of nursing and care staff were the immediate focus. There was a plan to involve families in developing the hospital's vision.

Vision, strategy innovation and sustainability for this core service

- The hospital has a long history and it had recently sought to redefine its specialism within the changing health economy in southern England. Clinical staff were confident that the hospital had unique assessment and management of disability skills in specific areas, particularly for patients with severe acquired brain

injury including prolonged disorders of consciousness, patients with Huntingdon's disease and patients requiring mechanical ventilation. The provider aimed to become a centre of excellence in these areas.

- The objective of finding 'ability in disability' was understood and supported by families and staff. Staff spoke of the challenge of helping relatives to have realistic expectations while maintaining hope. They said the new management was more open and had improved communications.
- Following renegotiation of tariffs for patients in the specialist nursing home, management believed that a steady income would make the new strategy sustainable.

Governance, risk management and quality measurement for this core service

- The board had a new chairman and some new members. There were eight executives and 15 trustees. The board met every two months which might not be often enough in a time of significant change.
- Some recent changes had been made to committees, both chairmanship and structures. The chairman reported that board members were more patient-focused and offered more challenge. He believed issues of significance were now always reported to the board. We noted there was no board secretary to advise on board responsibilities and monitor corporate governance.
- An internal clinical restructure in 2014 had created three distinct services: the Brain Injury Service, Specialist Services and the specialist nursing home. The chief executive was supported by an operational leadership team made up of the heads of the three services, the lead physician, matrons and therapy manager. The executive team met monthly. As the governance structure had been refreshed and many staff had only been in their current posts for a short period, a senior leadership development programme had been set up. A business transformation plan and a quality improvement programme had been designed. Managers considered the right foundations were in place. Clearly these would take time to embed. It was too early to judge whether the new systems would deliver the desired outcomes.
- Among the changes that had occurred was a high profile given to medicines safety. A new post had been created to oversee the governance of medicines.

Medical care

- The fit and proper person requirement had been recognised as a statutory requirement and we were told that new directors, trustees and executive directors would go through the new process. However, it is the responsibility of the provider to ensure that systems are in place to ensure that all directors meet the fitness test, and continue to do so; and do not meet any of the 'unfit' criteria. This system was not yet in place.
- The duty of candour to ensure that providers were open and honest with patients and their families when things go wrong with care and treatment seemed less well understood. No formal education for staff was yet in place to meet this legislative requirement. Following a request for further information after the inspection, the provider submitted to us, their draft 'Being Open Policy: Openness, Transparency and Candour', which was yet to be ratified. The intention that this policy will be signed off by the board in October 2015. We were also told that board members had received a formal briefing on the duty of candour in June 2015 by an external consultant.
- There was a board champion for end of life care.
- The management team were improving IT and starting to collect and use data more effectively, reviewing incidents and safeguarding to develop the hospital as a learning organisation and improve practice. More attention was being paid to the views of patients and their families in developing services that would be more patient-centred.
- Managers considered they had improved the identification and management of risk, and mitigation. The risks identified on the corporate risk register and the separate business transformation risk register reflected the key areas of risk that we identified in our inspection. Risks were reported to the board via the board assurance framework. However, we observed that risk was currently less well understood at ward level and work was needed to ensure learning was fully disseminated to achieve changes in practice.
- The specialist care home with nursing had a wide case mix, varying levels of acuity and a wide range of funding agencies. Placement reviews took place with the main clinical commissioning groups, who chaired the meetings and members of the MDT attended.
- Developing quality measurements to prove the success of rehabilitation in the group of patients with prolonged disorders of consciousness would not be an easy task for doctors and therapists.

Leadership/culture of service

- Staff and relatives considered the new chief executive to be visible and approachable.
- The head of nursing was aiming to change the balance of permanent staff to agency staff to improve continuity of care for patients, and establish a preferred provider list with a tighter governance framework for agencies. Existing nursing and healthcare staff would be given opportunities to increase their skills and remuneration, and recruitment and retention had been reviewed. The challenge of motivating staff when many patients were minimally responsive patients had been recognised.
- Managers were developing a culture where patients and their families were listened to and where staff wanted to work.
- Staff reaction to the many senior management changes over the last six months had led some staff to leave, but among the staff remaining the changes were mainly regarded positively. Despite some concern about the pace of change, morale was currently good. Staff were measuring morale through a Pulse survey which showed improvements in morale month on month. It was 61% in June 2015. Staff we spoke with felt that the direction of change was clear and that the right staff were there to deliver it. Three hundred and sixty degree feedback was being rolled out. Staff considered the hospital a friendly place to work.
- Managers were aware that morale needed to be sustained. Sickness levels were broadly similar to NHS at 4.5% (NHS 4%). Staff turnover had been nearly 18% in 2014 compared to an NHS average of less than 10%. Considerable effort was being devoted to better internal communication, including a weekly update from the chief executive.
- A new nursing structure led by matrons with ward managers and nurses in charge had been set up to strengthen nursing clinical leadership. Many of the nurses we spoke with said they felt valued by the organisation and some had worked there for many years. A nurse gave us an example of when nurses had felt listened to. This was when the post of deputy ward managers had been dropped but after discussions with staff, some of these posts had been reinstated. This nurse also said they had requested specific storage equipment and this had been granted. Nurses welcomed the idea that they could develop their rehabilitation skills as part of the new strategy.

Medical care

- Staff views were monitored through a regular survey. Managers took the survey seriously, particularly because it had in the past revealed concerns about harassment which they were trying address through establishing a more open culture with better communication.
- A supervisory development programme to be launched at the end of the summer to target ward managers was being well received.
- There was an annual awards ceremony for staff to recognise high quality care.
- The pace of change meant that we observed some communication gaps. For example, doctors had not been kept informed about some changes at ward level. The introduction of new locks on the doors of the medicine storage rooms had inadvertently resulted in defibrillators being locked away. The defibrillators had since been moved to more accessible areas, although they were now stored separately from the resuscitation drugs. A communication to staff was being issued to ensure that everyone was aware of the changes.
- Greater standardisation of practice between wards was being sought and staff we spoke with understood the reasons for this.
- Staff we spoke with felt poor performance was now being dealt with effectively by managers,
- Volunteers and new staff had valued the “in your shoes” pilot which had helped give them a patient’s perspective on being dependent on others.
- Staff reported that communication had improved in recent months and they felt more empowered to suggest change. Staff also said the HR department had improved and were now more proactive and visible. The weekly update from the chief executive was mentioned by medical and nursing staff as being helpful in keeping up with changes. The chief executive also held open forums which staff valued.
- Managers were working on a hospital organisational development programme with an external consultancy in recognition of the significant task of achieving lasting change.

Innovation, improvement and sustainability

Public and staff engagement

- A patient representative committee met every two months made up of patients and/or relatives (one from each ward) and volunteers. This was quite a large committee and most of the executive team also attended. It was a large group to make decisions although there was evidence of impact on service level issues. The process by which this group would impact on the transformation programme was not yet evident.
- A family peer support group had also been set up recently where families could exchange views on the challenges of having a family member with an acquired brain injury. There was potentially some overlap between this and the patient representative committee.
- Eye-gaze technology was an innovative form of electronic assistive technology to help people with very limited or no physical movement, such as people with motor neurone disease or locked in syndrome to communicate and make full use of computers. The hospital had successfully trained several of its patients to use this.
- The hospital offered good Electronic Assistive Technology Service to help patients communicate with others or independently control their environment, such as turning on a TV with an iPad.
- A project to teach staff to understand some patients' communications, even those with very complex needs was innovative in that it was led by a group of patients with severe disabilities. It would be designed and evaluated by patients. The premise on which the project was based was that “communication is the difference between a life and an existence”.
- The benefits of a specialist wheelchair provider on site meant that patients were able to obtain correct seating promptly.

Outstanding practice and areas for improvement

Outstanding practice

We found the following area of practice to be outstanding:

- Eye-gaze technology was an innovative form of electronic assistive technology to help people with very limited or no physical movement, such as people

with motor neurone disease or locked in syndrome, to communicate and make full use of computers. The hospital had successfully trained several of its patients to use this.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure appropriate medical cover for all patients at all times, particularly for those who need long term assistance with breathing for whom there was no in-house medical expertise.
- Improve the understanding of all staff on the range of potential safeguarding concerns that can arise with this patient group.
- Ensure that all staff comply with the Mental Capacity Act, 2005, with regards to consent, mental capacity assessments and Deprivation of Liberty Safeguards, including recording the detail of decision-making meetings about patients' mental capacity and best interests; and arrange for appropriate patients to have Independent Mental Capacity Advocates.
- Ensure that staff understand the legal requirements of the duty of candour in relation to being open and honest with patients and their families when things go wrong with care and treatment.

We found breaches of regulations in relation to the need for patient consent, the safe care and treatment and safeguarding service users from abuse and improper treatment. We have taken action against the provider and will report on this when our action is completed.

Action the hospital **SHOULD** take to improve

- Improve the coordination of medical care currently split between GPs and hospital doctors.
- Implement seven day therapeutic services for patients on the Brain Injury Unit.
- Involve families in decisions about Do Not Attempt Cardiopulmonary Resuscitation and End of Life care and ensure these conversations are documented.
- Improve the training and support for permanent and agency nurses and healthcare assistants including safeguarding, resuscitation and for nurses the full range of competences needed to care for all patient groups in the hospital.
- Improve the choice and presentation of the food provided.
- Individualise the goal planning for all patients in the hospital.
- Improve patient flow through the hospital by reducing the length of stay of appropriate patients.
- Where appropriate, make the environment for long stay patients more 'homely' in line with current expectations of facilities for residential accommodation.
- Actively encourage family involvement on all wards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users because; 1. All staff did not understand the range of potential safeguarding concerns that can arise with this patient group. Regulation 13 (2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The provider did not systems and processes to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity because; 1. Staff did not understand the legal requirements of the duty of candour in relation to being open and honest with patients and their families when things go wrong with care and treatment. Regulation 20