Thames Brain Injury Unit

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Thames Brain Injury Unit as requires improvement because:

- There were no governance systems place and there had been a number of changes in both the clinical and managerial positions in the 18 months prior to the inspection.
- Staff told us that there was poor morale in the service.
- There had been gaps in significant audit programmes such as medication audits, infection control audits and care planning audits in the year prior to the inspection so systems were not in place to monitor quality.
- There were significant gaps in mandatory training including key training such as safeguarding adults.
- Staff had not received regular supervision and team meetings were not taking place to share information related to the service and how it could improve, in the year prior to the inspection.
- Incidents were not regularly reviewed and there was a significant backlog in incidents which needed to be reviewed at the time of the inspection.
- While the service had a complaints policy, there was not a clearly recorded pathway tracking how and if the service had responded to complaints made.
- Some care plans were not holistic and were narrowly focussed on nursing needs.
- Incidents of restraint were not being recorded correctly on incident forms which meant that the figures may not be understood correctly by the service. We also saw an example of one incident of seclusion in a patients' bedroom which had not been recorded as seclusion and therefore the protections added by the Mental Health Act Code of Practice had not been reflected.
- There was no process in place to screen all patients who may be at risk of developing pressure ulcers on and through admission.

However,

- A new hospital director had been appointed shortly before the inspection and there were updated infection control and medication audits in the two months prior to the inspection where an interim management team were put in place.
- There was a strong multi-disciplinary team and patients had access to a wide range of therapies.
- The environment was clean and hygienic with space necessary for meetings, activities and quiet areas.
- The service had made some changes and appointed a nurse to lead on improving the time from referral to assessment.

Summary of findings

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Summary of this inspection

Background to Thames Brain Injury Unit

The Thames Brain Injury Unit is one of two units that form the Blackheath Brain Injury Rehabilitation Unit. It is registered as a hospital to provide care and treatment for up to 17 people who have mental and/or physical health problems resulting from an acquired brain injury.

It is part of the Huntercombe Group which is a division of the Four Seasons Group.

At the time of our inspection, 10 beds in the unit were occupied and the unit was mixed gender.

The CQC has registered Thames Brain Injury Unit to carry out the following activities:-

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Accommodation for persons who require nursing or personal care.

The Thames Brain Injury Unit has been registered by the CQC since 2012.

There have been six inspections carried out at the Thames Brain Injury Unit prior to this inspection. At the last inspection in November 2015, which was a focussed inspection following up previous non-compliance identified, there were no outstanding regulatory breaches.

The registered manager for the service no longer works for the provider. We were informed during the inspection that the hospital director would be making an application to become the registered manager for the service.

Our inspection team

The team that inspected the Thames Brain Injury Unit comprised of four CQC inspectors, two of whom were shadowing the inspection, one CQC assistant inspector, one Mental Health Act Reviewer, one specialist advisor who was a nurse and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service and requested information from the provider. We also requested additional information following the inspection.

During the inspection visit, the inspection team:

- Spoke with four patients and two family members
- Received feedback from nine comments cards

Summary of this inspection

- Visited the hospital site and looked at the quality of the ward environment and observed how staff interacted with patients.
- Spoke with the newly appointed hospital director, the interim hospital director who was handing over to the newly appointed hospital director, the interim ward manager and the regional lead nurse for the provider.
- Spoke with 17 other members of staff including doctors, psychologists, the health and safety lead, the human resources lead, therapists, social workers, nurses and rehabilitation assistants.
- Spoke with the advocate who visits the service twice weekly.
- Attended one clinical team meeting
- Reviewed 10 prescription charts.
- Reviewed five care records.
- Received feedback from NHS England, Lewisham CCG and Lambeth CCG who commission services in the unit.
- Checked 73 incident reports.

What people who use the service say

During the inspection, we spoke with four patients and one family member. Patients told us that the staff respected them and the feedback was mostly positive about the support provided. Two people told us that there were not many activities. However, one person said they were happy with the activities provided.

Most comments cards were positive mentioning the kindness and responsiveness of staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Essential audits such as infection control and medicines audits had not consistently taken place monthly for six months prior to the inspection.
- There were significant gaps in mandatory training for all staff and for some nurses and rehabilitation assistants there were no training records available meaning it was not also clear where the gaps in training were.
- Restraint which had taken place was not always recorded as restraint in the incident reporting database which meant that the data provided relating to restraint may not be accurate. An incident of seclusion had taken place without recognition that it was seclusion as defined in the Mental Health Act Code of Practice.
- There were some gaps in individual risk assessments and some risk assessments had not been updated in a timely manner following incidents which had occurred.
- Incidents were not reviewed in a timely manner and there was no clear documentation that learning from incidents occurred.
- The service had carried out a ligature risk assessment which identified potential ligature anchor points. The risk management plan stated that risks would be managed locally without any detail about how that would be done.

However,

- Audits had taken place in the two months prior to the inspection following a new management team being in place although identified actions from these audits had not yet been embedded.
- The ward environment was clean.
- Most staff knew how to report incidents and reported incidents appropriately.
- Emergency equipment was available.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans were inconsistently completed and were not holistic. For example, physical health care needs and social needs were not consistently reflected in care plans which focused on medical and nursing needs.

Summary of this inspection

- There was an inconsistent approach to monitoring and screening people who were at risk of developing pressure ulcers. The decision to screen or not to screen for pressure ulcers was not clearly documented in patients' records.
- Nurses and rehabilitation assistants had not had regular access to clinical and managerial supervision reflecting the provider's supervision policy.

However:

- There was a strong multi-disciplinary team where patients had access to a wide range of therapies and therapists as well as having social workers based on site.
- There was an understanding of the NICE recommended pathways relevant to patients in the service and therapeutic goals and plans were clearly recorded.
- Patients were screened for risk of falls by the physiotherapy teams.
- Physical health checks were regularly undertaken.

Are services caring?

Good

We rated caring as good because:

- The feedback we received from patients was positive and reflected that patients felt safe and supported by staff in the service.
- We observed positive interactions between patients and staff.
- There was strong advocacy representation in the hospital with an advocate visiting regularly and following up concerns raised.

However:

- Some care plans did not reflect patients' views and were not person centred

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- At the time of the inspection, there were 20 patients on the waiting list to come into the service. There were two patients whose discharge had been delayed. The service's target for referral to assessment was 10 days and this was not being met.
- Some staff and patients told us that the activities programme was limited, particularly at the weekends when there were fewer staff.
- While the provider had a complaints policy in place, it was not clear how information from complaints led to improvements

Summary of this inspection

and changes in service. We saw an example of one complaint which had not been followed up. This meant we could not be assured that the complaints process was effective in driving improvements in care.

However:

- The service had undertaken a review and appointed a lead on discharge co-ordination. This role was to ensure that the process to review referrals and assessments as well as to plan discharges was monitored and that delays could be addressed promptly
- The service regularly reviewed and discussed referrals, assessment and discharges in meetings.
- The hospital environment had two lounge areas, a gym and quiet rooms.
- Patients had access to interpreters and translation services if they required it. There was a multi-faith room and patients could access appropriate diets reflecting their religions, such as Halal food, if they required it.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The service did not have robust governance systems in place at a local, regional and national level, which identified concerns within the service and then ensured that action plans were followed. For example, while there was a local assurance framework in place, the responsibility to act on plans, which had defined time scales had not been happening.
- There had been a number of changes in management and clinical leadership in the service over the eighteen months prior to the inspection. This meant that any changes had not embedded.
- There were significant gaps in mandatory training, supervision and regular auditing processes which had been identified at inspections and through internal processes over the year prior to the inspection but this had not led to changes being embedded in the service.
- Some staff told us that morale was low, particularly among nurses and rehabilitation assistants. This was due to the lack of consistency in management.

However:

- A new hospital director had come into post shortly before the inspection and the provider told us that a new management structure was to be put place.

Summary of this inspection

In June 2016, shortly after the inspection visit, we served a warning notice on the provider in relation to Regulation 17 Good Governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. More information can be found at the end of the report.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

One patient was detained under the Mental Health Act at the time of our inspection. The relevant paperwork was in place. Staff on the ward had some understanding of the Mental Health Act and were able to seek assistance where necessary and had access to a copy of the Mental Health Act Code of Practice.

There was a Mental Health Act administrator on site who was able to check paperwork as necessary. Staff had access to a copy of the Mental Health Act Code of Practice to refer to.

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw that in the ward round prior to our inspection, capacity had been discussed by the ward consultant, who was new in the role. Staff understanding of the Mental Capacity Act was mixed which reflected the levels of training on the unit. At the time of the inspection, three patients were subject to authorisation under the deprivation of liberty safeguards and five patients had been referred for assessments from their local authorities.

Requires improvement

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Requires improvement

Safe and clean environment

- The ward environment was clean.
- There were some blind spots on the ward which were mitigated by staff observation of patients who had higher needs both relating to their physical and mental health. The ward had conducted a ligature risk assessment. However, while risks were identified, it was not clear how each risk was managed as the risk assessment stated that risks were 'managed locally' but did not detail how the risks were being managed on the unit.
- The ward complied with guidance regarding same-sex accommodation. There were separate male and female corridors with different lounge areas including space for women. Toilets and bathrooms were located in each of the respective corridors.
- The service had an infection control lead nurse as well as the interim ward manager who had been taking a lead on infection control in the service and had conducted two thorough monthly infection control audits in the time which she had been in post. We saw infection control audits which had been carried out in March and April 2016 but there had not been consistent and regular infection control auditing prior to that.
- The service had a health and safety lead and environmental risk assessments had been carried out. The clinic room was clean and there was adequate sharps and clinical waste disposal.
- Equipment for emergencies such as oxygen and a defibrillator was present and available for staff to use if necessary. Routine equipment used to carry out health checks such as blood pressure monitors were checked and calibrated regularly.
- Staff had access to call alarm systems which were checked regularly. Patients had access to call alarms in their bedrooms.
- There was a separate team of domestic staff who worked over seven days. The service had ensured that cleaning rotas which detailed areas of the ward to be cleaned were completed. However, these were not consistently signed by a supervisor. We found that the fridge in the clinic room where medicines were stored had not been cleaned regularly for two months and was not clean at the time of our inspection. This was a responsibility of the domestic staff.

Safe staffing

- At the time of the inspection, the ward had ten patients. The staffing levels were two registered nurses on duty at all times, day and night with three rehabilitation assistants. The numbers of rehabilitation assistants were increased when patients were on closer observation levels and staff told us that this happened when it was necessary. During the week, between Monday and Friday, some therapists who were working elsewhere in the service were available to assist with some tasks such as moving and handling when necessary.
- Three members of staff told us that there were times when it was difficult to manage the necessary tasks related to moving and handling, particularly at the weekend, due to the lack of availability of additional support when some transfers needed to take place.

Requires improvement

Services for people with acquired brain injury

- Between September 2015 and February 2016, 322.5 shifts had been covered by agency staff.
- In 12 months between February 2015 and February 2016, there had been a 25% turnover rate of staff.
- The ward had a consultant neuropsychiatrist who provided cover on one day a week and was the responsible clinician for patients detained under the Mental Health Act. There was also one associate specialist who was on the unit for four days a week. The service had access to a doctor on call at weekends and in the evenings.
- Mandatory training records showed that mandatory training was not being completed. Out of 13 full or part time rehabilitation assistants whom we were provided with training records for, seven had not completed adult safeguarding training. Four had not completed moving and handling training and one had completed no mandatory training. Out of seven full or part time nurses, one had completed no mandatory training, and two had not completed adult safeguarding training. Eight out of 20 members of staff had not completed MCA training. This meant that there was a risk that staff were not suitably trained to carry out the tasks which they were required to do.

Assessing and managing risk to patients and staff

- In the three months between 1 March 2016 and 26 May 2016, the service recorded eight episodes of restraint, none of which were in the prone position. However, when we reviewed individual incident reports we saw that some incidents where there was evidence of restraint taking place had not been recorded as restraint. For example, one incident report dated 11 October 2015 stated that a 'walking restraint' was used but there was no additional information about this. This meant that there was a risk that all restraints including precautionary holds were not being recorded accurately.
- Managers in the service reported to us that seclusion was not used. There was no separate seclusion room in the service. However, in our review of incident reports we saw one example, dated 11 October 2015 where a patient was prevented from leaving their bedroom for several hours by members of staff due to the risk to themselves or others. One member of staff told us about another situation which they had believed would be an incident of seclusion. This meant that there was a risk that seclusion was not comprehensively recognised and recorded by all staff and that the protections afforded in the Mental Health Act Code of Practice may not be being upheld.
- We checked the risk assessments of four patients. Risk assessments were completed on the electronic database system by nursing staff when a patient was initially admitted to the ward. We saw that there were summary risk assessments which related to broad risk areas and these were supplemented by more detailed risk assessments which related to specific risks. For example, one person had a specific risk assessment relating to the management of the health of their feet as it was an issue that particularly concerned them.
- For one patient who had been in the service for over one month, we saw that there was only a summary risk assessment and no detailed risk assessments had been completed. We saw two other individual risk assessments which had not been completed at the time the risks had been identified for patients. This meant that there was a risk that all staff may not have a good understanding of current risks and how they were managed when providing care for patients. One member of staff told us that they saw that physical health risks were managed and assessed but that mental health risks were not as robustly managed. We saw that therapy staff including physiotherapists who carried out falls risk assessments and speech and language therapists who carried out communication assessments were involved in producing documentation.

- The medicines were supplied by an external company who delivered medicines every four weeks. Two members of staff told us that there had been difficulties in receiving regular deliveries which meant that sometimes medicines that had been ordered did not arrive when they were needed. There were two incidents that took place between 1 April 2016 and 30 May 2016 where prescribed medication had not been available for patients as it was out of stock and had not been delivered.
- We checked ten patient prescription charts and they were updated with patients' current medicines. However, patients were on significant numbers of different medicines and this meant that some people had more than one chart which they used concurrently as all the medicines which they receive did not fit on

Requires improvement

Services for people with acquired brain injury

one chart. For one person, we saw that a PRN (as needed) medication had been written up in duplicate on both medicines charts. This meant that there was a risk that they may receive double the prescribed dose if a nurse were looking at the wrong prescription chart.

- Medicines audits were carried out by nursing staff and had been most recently, in April 2016 and May 2016, been carried out by the ward manager. There had been gaps in medicines auditing prior to that.
- Most staff had a good understanding of safeguarding and were aware of how to raise concerns. There was a member of staff who led on safeguarding reports within the service.
- The service had developed a business contingency plan which detailed actions to take in the event of an emergency.
- The service had a policy relating to visitors to the ward, including children who visited the ward. There was space on the ward for visiting family members.
- Recruitment checks, such as ensuring staff had been checked through the disclosure and barring service prior to starting employment were carried out centrally by the organisation's human resources team. We checked that these had been undertaken and that references were taken up before employment commenced.

Track record on safety

- Incidents were reported using an online database. We checked records of all incidents reported between 1 March 2016 and 22 May 2016. Seventy four incidents were reported which included near misses. Thirty three incidents related to verbal or physical abuse directed at members of staff, which was the highest single category.

Reporting incidents and learning from when things go wrong

- Most staff we spoke with were aware of how to report incidents using an online reporting system. One member of staff told us that incidents were reported on paper. Another member of staff told us that sometimes incidents which occurred over the weekend were not reported until permanent staff were on duty on the following Monday.
- We checked a number of incident reports and found that many contained detailed information. When incidents were reported they were cross-referenced and recorded in the electronic record system.
- There was one member of staff who administered the reporting system and checked incidents as they were reported to allocate to the most appropriate manager or member of staff responsible.
- When we checked this database on 24 May, there were 274 open incidents which had not been investigated and out of these 251 were deemed to be 'overdue' where overdue means that 20 days had elapsed since the incident occurred. This meant that there was a risk that information from incidents was not being reviewed, which could lead to additional learning and actions from learning not being implemented. As a result, patients were potentially at risk of avoidable harm.
- Staff and managers at the service were aware of the obligations required by the duty of candour.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at the care plans, risk management plans and daily records for five patients. We saw that care plans were completed. However, care plans were inconsistent and were not holistic. There was not a consistent approach to care planning with a holistic focus. For example, care plans focused on medical needs, both physical and mental and there was not a focus on social needs. One member of staff told us that while social factors may influence the delivery of care and treatment, these issues were not always addressed in care planning.
- One patient, who had been admitted on 29 July 2015 had their first care plans completed on 23 May 2016.
- The ward manager had conducted an audit of care plans and risk assessments in May 2016 which had identified poor quality recording of care planning. This was being addressed at the time of the inspection. However, it meant that there had not been effective auditing for the months prior to the inspection. There was an action plan resulting from the audit which reflected our findings that care plans were not comprehensively completed and did not reflect effectively patient's views.

Requires improvement

Services for people with acquired brain injury

- Physical health checks were completed on admission and we saw that there was regular recorded monitoring of physical health problems. However, these were not consistently reflected in care plans. Staff had a good understanding of the physical health needs of patients.

Best practice in treatment and care

- Staff told us that references to NICE guidance were discussed in clinical team meetings where each patient's care was discussed. We saw that minutes from these meetings reflected updated guidance. This was reflected in the therapy plans for patients.
- There was a psychology department on site which supported patients with both individual and in group therapy. Patients also had access to a broad range of recovery-focused therapies and staff in this team had access to current NICE guidelines which formed the basis of therapeutic intervention plans.
- The service had a contract in place with a local GP. This had been relatively new. The GP visited the service regularly.
- We saw that while patients were screened for falls by the physiotherapy team, there was no consistent screening for pressure ulcer development using a recognised tool such as Waterlow or Braden scoring. Patients using this service may have been at risk of developing pressure ulcers where their mobility was impaired. Where a decision had been made not to screen for pressure ulcers, this was not clear in the records.
- Some of the therapy teams were making effective use of outcome measures such as functional behaviour assessment interviews and a motivation assessment scale used by the psychology team and balance and walking tests used by the physiotherapy team. The occupational therapy team told us that their meetings regularly discussed relevant national guidance. The psychology team were aware of relevant guidance in our conversations with them.

Skilled staff to deliver care

- The service included, as well as medical and nursing staff, occupational therapists, social workers, physiotherapists, speech and language therapists as well as domestic and kitchen staff. The focus was very much on multidisciplinary working and the weekly multidisciplinary team meetings included representatives from each profession when discussing patients' needs.
- We looked at supervision records for seven members of staff. Between 1 January 2016 and 24 May 2016, four members of staff had only received supervision once. Two members of staff had received formal supervision twice in this period. The organisation policy stated that clinical and managerial supervision should be delivered regularly, not less than six to eight weekly. Rehabilitation assistants and nursing staff we spoke with told us that they were not receiving supervision at the level specified in the policy.
- The service was not able to provide us with collated evidence of supervision levels during the last six months. The organisation supervision policy states that supervision records should be audited annually. There was no evidence that this had happened.
- The service offered facilitated reflective practice groups which were led by the consultant psychologist. Two meetings took place in March 2016 and May 2016.
- One member of staff told us that their most recent supervision meeting had been 20 minutes and that they had not felt this had been sufficient. Another member of staff told us that they had had supervision once in 12 months.
- In previous CQC inspections of the service, there had been a lack of regular clinical and managerial supervision for nursing staff. There was a lack of learning from issues which had previously been identified as lacking.

Multi-disciplinary and inter-agency team work

- There was a strong multi-disciplinary team in the service which included a range of health care professionals and social workers including speech and language therapists, psychologists, occupational therapy and other disciplines that combined to provide a comprehensive range of support for patients.
- We attended one multi-disciplinary team meeting during the inspection and saw that different members of the team worked well together and were able to input into the care planning for people who used the service.

Adherence to the MHA and the MHA Code of Practice

- We checked relevant paperwork relating to the detention of one patient who was detained under the Mental Health Act. Appropriate papers such as original detention records in place.

Requires improvement

Services for people with acquired brain injury

- The provider had policies relating to the use of the Mental Health Act and staff were aware that they could seek guidance if necessary.
- We saw that where there was a patient who was detained, they were given information about their rights to appeal against their detention and this information was repeated regularly and was documented.
- Training related to the Mental Health Act was not mandatory. Staff had some understanding of their roles under the Mental Health Act.
- There was a Mental Health Act administrator on site who was able to check paperwork as necessary. Staff had access to a copy of the Mental Health Act Code of Practice to refer to.

Good practice in applying the MCA

- The ward consultant was new to the service. He told us that he reviewed capacity during weekly ward rounds. We saw that this was recorded in patients' notes and that capacity was considered in relation to people's care and treatment.
- Some staff had received training related to the Mental Capacity Act and the Deprivation of Liberty safeguards. However, out of 13 full and part-time rehabilitation assistants, six had not completed training specifically related to the Mental Capacity Act. One nurse had not completed training related to the Mental Capacity Act. This meant that, given the nature of people who used the service, there was a risk that some staff may not be aware of their responsibilities related to this legislation. However, staff we spoke with showed mixed understanding. Some were very well aware of the responsibilities and framework of the act.
- At the time of the inspection, three patients were subject to authorisation under the Deprivation of Liberty safeguards and five patients had been referred to the local authority where authorisation had been requested.

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support

- We spoke with four patients and one family member of a patient and collected feedback from nine comments cards which had been left for us. Most of the feedback we received was positive and patients told us that they were treated with respect. We observed that interactions between staff and patients were sensitive and patient focussed.
- Staff we spoke with across the service, including nurses, allied health professionals and rehabilitation assistants who had a good understanding and awareness of the needs of individual patients.

The involvement of people and their carers in the care they receive

- The service had an advocate who visits the unit twice a week. The advocacy service provided support for patients to raise concerns and also attended clinical governance meetings in order to raise patients' issues and ensure that they were captured locally.
- The advocacy service completed an annual survey about patients' views on care, food and the environment. The feedback from this survey was presented to the provider to feed into the broader governance processes within the organisation.
- The service had a carer's group which met monthly.
- Patients' family members had the opportunity to provide feedback about the service. One family member told us that they were happy with the service but another family member told us that they felt there could be better communication.
- There were weekly community meetings where patients were able to feedback about the service. We saw an example of where a change had been made following feedback, where families had asked to be given activities plans for the week on the Friday for the following week rather than the Monday morning so that they could make better plans for the week. This had been implemented.
- Some patients told us that they did not have copies of their care plans and it was not consistently clear how people's voices were reflected in their care plan documentation.

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

Requires improvement

Services for people with acquired brain injury

(for example, to feedback?)

Requires improvement

Access and discharge

- One senior nurse has been appointed to lead on discharge co-ordination including reviewing referrals and assessments and monitoring the times from referral to assessment as well ensuring prompt discharge from the service. This post was created as a response to the delays which had occurred in the assessment processes and was a result of consultation with commissioners about managing this.
- The service had a smaller assessment, discharge and transfer meeting specifically with the ward consultant and heads of department attending to focus on screening referrals and monitoring discharges which have been delayed.
- Between September 2015 and February 2016, the average length of time between referral and assessment was 27 days. The target from commissioning bodies was 10 days.
- There were two patients whose discharges were delayed at the time of the inspection.
- The average length of stay on the unit was either 12 or 24 weeks depending on commissioning arrangements in place. However, there were some people who had been in the service for significantly greater periods of time. For example, one patient had been on the ward for thirteen years. At the time of the inspection, their discharge was being facilitated.
- We were told by the provider that at the time of our inspection, there were twenty people on a waiting list to come into the service.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward was on the ground floor and there was a male and female corridor. There was a quiet room as well as two lounge areas and a gym.
- Patients were able to personalise their bedrooms if they chose to.
- There was a comprehensive therapy programme during the week. However, the programme did not cover the weekend when therapy staff did not work. We were told by staff during the inspection about activities and trips which went ahead such as to a sailing group for some patients. However, two patients and some staff told us that there were few activities taking place at weekends when there were fewer staff. There was little evidence of activities programmes outside therapy involving all patients, such as having timetables of leisure and recreational activities on display.

Meeting the needs of all people who use the service

- The service had access to interpreters and were able to access them when necessary to communicate with patients and their family members. Staff were aware of the processes to book them. Staff also told us that they had access to translation services so that information specific to individual patients, was translated into their native languages.
- The service was on the ground floor and was wheelchair accessible. Staff undertook training in equality and diversity. There was a small multi-faith room which was also a quiet room and patients had access to religious materials. Patients told us that they were able to access appropriate diets, such as Halal food, when required.

Listening to and learning from concerns and complaints

- The service had a clear complaints policy which was visible in the ward area. We reviewed three complaints which had been received by the service in the year prior to the inspection. These complaints related to patient care, a medication error and a patient assault.
- We checked minutes from clinical governance meetings in between January 2016 and April 2016. We saw that complaints were discussed at one meeting and it was not clear from the minutes that information was shared as the minutes referred to a compliment being logged. There was no discussion of informal complaints and concerns which meant that there was a risk that comprehensive information about people raising concerns through informal channels was not being captured.
- We saw that the service had established a log of formal complaints received in the service. There was little information in this log about how complaints had been resolved. We saw an example of one complaint out of the three in the year prior to the inspection, which had been received but had not led to further action or been

followed up. We raised this during the inspection. This meant that there was a risk that the provider's complaints policy was not being implemented effectively.

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

Inadequate

Vision and values

- There had been a number of changes in the management structure in the unit in the 18 months prior to the inspection. An interim hospital director had been appointed in March 2016 until a substantive replacement was in post. They had been appointed in May 2016. Some members of staff we spoke with told us that these changes had had an effect on their morale and that it had not always been clear who the management team were. This also impacted on staff engaging with and understanding the providers' visions and values. One member of staff told us that they were not clear about where the clinical leadership on the ward lay as there had also been a high number of consultant psychiatrists in the year prior to the inspection.
- Some staff told us that they felt detached from the provider organisation and had not felt that they were consistently listened to. In the month prior to the inspection, the provider and new management team had started 'open door' meetings between the management and staff. A change management consultant had been moved into the service to provide additional support to the staff and management team for a period of a few months while a new management team embedded. An acting ward manager and an acting hospital director had been in place for six weeks prior to the inspection, however, there role was intended to be short term. The position of ward manager was open to applications at the time of the inspection as the acting ward manager was due to leave shortly after the inspection.

Good governance

- The service did not have an effective governance systems in place. This resulted in significant shortfalls in the provision of the service. For example, there were significant gaps in training records including mandatory training such as safeguarding adults. Supervision rates had improved since the acting ward manager had come into post but there had been gaps in supervision over the year which had been identified in the service's assurance framework but little action had been taken.
- The service had a specific assurance framework which detailed risks to the service based on information which was gathered on site. This provided information from the service to the provider head office. However, where targets had been set in the assurance framework dated January 2016 with actions which were due to be completed in February 2016, they had not been completed by May2016. It was not clear what actions had been taken between January and May to action targeted concerns. For example, there was an action point in January which stated staff supervision for nurses needed to increase from 40% - 50% with an action date of February 2016.However, this action was still present in the June 2016 copy. This meant that there was a risk that identified actions would not be completed in the timescales indicated.
- There were some significant gaps in auditing in key areas such as medication management. We saw that there had been two medication audits in April 2016 and May 2016, but the audits prior to that had been completed in February 2015, March 2015 and July 2015. This did not reflect the provider's policy which stated that audits should take place monthly.
- We were provided with minutes from one team meeting over a period of a year which had been held in May 2016. Other mechanisms to discuss concerns, complaints, incidents and learning were limited. Some staff had not received regular supervision so this meant that there were not robust systems in place to ensure that the service was developing and improving constantly.
- Some recent audits had been undertaken by the interim management team such as care record audits and infection control audits but these had not yet become embedded in the service as the interim team had been in place for 6 weeks.

Leadership, morale and staff engagement

Requires improvement

Services for people with acquired brain injury

- Some staff told us that morale in the service had been low for about six months and some told us that they valued the support of the interim management team and were concerned about the impact that this would have when they left the service.
- Four members of nursing staff told us that they felt there were divisions between the nursing team and the therapy teams. Two members of staff told us that they thought this was improving.
- In the six months prior to the inspection, four members of staff had been dismissed on the grounds of capability. Two members of staff were suspended at the time of the inspection. Between September 2015 and February 2016, the sickness rate was 20%. During the inspection, we were told that four members of staff were long term sick. This reflected some of the poor morale in the service and the changes in leadership which staff told us had had an impact on them.
- Staff we spoke with had an understanding of the organisation's whistleblowing policy and told us that they would feel comfortable raising concerns.
- The provider offered those who left, the opportunity to complete exit questionnaires but told us that no one who had left over the previous year had taken this opportunity.
- Two members of staff told us that the change process had been very difficult particularly as there had been frequent changes in management.
- Some staff told us that they did not feel there were opportunities available to develop.

Commitment to quality improvement and innovation

- The lead psychologist in the service had adapted assessments and questionnaires to tailor them to the user group, for example, ensuring mood questionnaires had a more visual component to need the needs of patients who had cognitive impairments.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that robust governance systems are in place so that the provider and manager have an oversight of the performance of the unit and so that gaps in quality such as low rates of supervision, medication errors, rates of mandatory training and incident reporting can be monitored
- The provider must ensure that action taken following complaints is recordedand that learning from complaints and concerns are embedded in learning for all staff.
- The provider must ensure that restraint and seclusion is recorded and that safeguards specified in the Mental Health Act Code of Practice are followed.
- The provider must ensure that incidents are investigated within expected time limits and learning is identified so that appropriate action can be taken to manage risk in case of future occurrences.
- The provider must ensure that there are clear arrangements in place to manage the risks of ligatures and ligature anchor points in the service and that staff are aware of these.

Action the provider SHOULD take to improve

- The provider should ensure that care plans and risk assessments are completed comprehensively and in a timely manner to reflect the need of patients in the service.
- The provider should ensure that a detailed management plan follows ligature risk assessments.
- The provider should ensure that where there is a potential risk, patients are screened for the risk of pressure ulcers.
- The provider should ensure that cleaning checklists are countersigned to ensure that all areas of the ward, including the fridges in the clinic room, are cleaned regularly.
- The provider should ensure that all staff working in the service are aware of how to report incidents in a timely manner.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not ensuring that when managing risks to the patients and their environment, all steps had been taken to mitigate risks by the lack of a clearly development ligature risk management plan which followed from the ligature risk assessment. Also the service had not investigated incidents in a timely manner and therefore ensured that any learning from incidents could be used to prevent future incidents occurring. This is a breach of regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that a system was in place to protect service users from abuse and to operate effectively if the service became aware of any allegations of abuse. Systems and processes to investigate and act on the use of restrictive practices were not in place as records of incidents of control and restraint were not complete. This is a breach of regulation 13 (1) (2) (3) (4) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider was not ensuring that a system was in place to effectively receive and manage complaints The complaints system in place was not effectively handling and responding to complaints by service users and other persons in accordance with the complaints policy. This is a breach of regulation 16 (1) (2)
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that staff had receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they are employed to perform as staff had not had access to regular supervision as reflected in the provider's supervision policy. This is a breach of regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity and also to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity. Incidents were not reviewed in a timely manner which meant that learning from incidents could be lost. Team meetings were not taking place and the clinical governance meetings which took place monthly, did not consistently reflect discussions relating to incidents which had taken place in the service. Staff had not received regular clinical and managerial supervision and there were gaps in mandatory training. Care plans and risk assessments were not updated to reflect current patient needs and there were gaps in the medication and infection control audits in the year prior to the inspection. This was breach of Regulation 17 (2) (a) (b) We served a warning notice on the provider in June 2016 and require the service to be compliant by October 2016.