Royal Hospital for Neuro-Disability

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

Overall summary

The Royal Hospital for Neuro-Disability (RHN) 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.

At our last inspection in March and April 2017, this provider was rated as Good overall. Safe was rated as Requires Improvement. All other key questions were rated as Good. This is a report of a focused inspection of the long-term conditions service we carried out on 16 July 2018. We carried out this inspection in response to concerns about some incidents the provider had notified us of. These were concerns about assessing and responding to patient risk, including care for deteriorating patients, prevention of pressure ulcers and learning from incidents, in the long-term conditions core service. As this inspection was focused on specific areas of concern, we did not look at all aspects of all key questions, and we have not re-rated this service.

On our last inspection, we found areas where the provider needed to improve. We issued the provider with a requirement notice, telling the provider to make improvements, in order to meet legal requirements. Therefore, we also followed up on these areas during this inspection. These were as follows:

The provider must:

- Ensure ward staff have more training both on the different degrees of decision-making ability among patients and residents, and the types of decisions each can make, and on the risks to patients and residents of not following the guidance for eating and drinking.
- Ensure all staff have an annual appraisal.

Our key findings from this inspection were:

- The hospital had completed the actions of the requirement notice we issued on our last inspection. Ward staff had improved training on the risks to patients and residents of not following guidance for

Summary of findings

eating and drinking. Ward staff had more training on the different degrees of decision-making ability amongst patients and residents, and the types of decisions each could make.

- All staff received an annual appraisal.
- Staff knew how to assess and respond to patient risk, and could explain the processes for doing so.
- Prevention, identification and management of pressure ulcers was generally well managed.
- Residents of the specialist nursing home had all aspects of their care plans reviewed in line with national practice.
- Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate. Learning from incidents was shared amongst staff.
- Staff awareness of the need for reasonable adjustments to help patient decision-making had improved.
- The complaints handling process had improved, with a more structured approach and measures to determine whether complainants were satisfied with the outcome.
- Leaders understood the challenges to quality and sustainability and could identify actions needed to address them.

However:

- Patient records were not always consistently detailed or complete. Recording of key clinical interventions such as completing turning charts, and escalation of NEWS scores, were inconsistent. This meant there was a risk that patient care records were not always accurate, which could result in patients not having their care needs met, particularly by new or temporary staff who were not familiar with the patient. Staff told us that they did not always have time to complete care records thoroughly. Senior leaders were aware of this, and had introduced some pilot mitigating actions, but these were not yet embedded.
- Hand hygiene audits showed mixed results, although they had improved since our last inspection.
- We found one instance of where a patient's fluid balances were not monitored systematically, as they had not been totalled. Totalling fluid balances is important to ensure that patients are optimally hydrated. This was an action we told the provider they should take to improve at our last inspection. We highlighted this to staff during inspection, who corrected the lack of totals. However, it should be noted that this was an improvement on our last inspection, where we found we did not find any charts where scores had been added up.
- Sections of care plans covering the Mental Capacity Act (MCA) were not always sufficiently detailed, and senior leaders did not always robustly monitor this. These sections, referred to as MCA care plans, contained details as to whether a patient could make some, none or all decisions for themselves. Where a patient could make 'some' decisions for themselves, details of what this meant were not listed. MCA care plans were reviewed as part of the hospital's programme of mock inspections, but there was no formal audit programme for MCA care plans. Senior leaders told us they tried to set aside time monthly to look at MCA specific care plans, templates and data, but this was not always possible.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Royal Hospital for Neuro-Disability

The Royal Hospital for Neuro-Disability (RHN) is a residential independent hospital run by a charity. It is located in Putney, West London. The hospital opened in 1854 and has been in the current location since 1863. The hospital is in a three-storey listed building with a basement area used by administrative staff. Patients and residents come mainly from London and southern England, but some come from other parts of England. RHN provides acute assessment and rehabilitation for 46 patients with severe brain injuries or illness through the NHS England Specialist Rehabilitation Contract. The hospital provides specialist help to patients with a wide range of complex neurological disabilities caused by damage to the brain or other parts of the nervous system as a result of brain haemorrhage, traffic accidents or progressive neurological conditions. It includes people who are highly dependent and have complex care needs, people in a minimally aware state, people with complex behavioural needs, and people needing mechanical ventilation. RHN has a high dependency nursing home providing long term care for about 122 residents who have become disabled following a brain injury.

RHN is registered to provide diagnostic and screening activities, diagnosis and treatment, accommodation for people needing nursing or personal care and transport, triage and medical advice provided remotely.

The Chief Executive had been the registered manager since March 2018. The hospital was registered for 260 beds, with 223 currently in operation.

At the time of the inspection, RHN employed 10.1 whole time equivalent (WTE) doctors and 0.45 WTE dentists. A Wandsworth-based GP provided medical services to residents of the specialist nursing home and to patients with Huntington's disease.

The hospital employed 68.5 WTE qualified allied health professionals (AHP) and 56.5 WTE support AHPs. Allied Health Professionals include physiotherapists, speech and language therapists and occupational therapists.

RHN employed 104.8 WTE registered nurses and 170 WTE healthcare assistants as well as having its own bank staff to cover staffing shortfalls.

Our inspection team

The team that inspected the hospital comprised a CQC lead inspector, two other CQC inspectors, an assistant inspector, and a specialist advisor with expertise in neurology and long-term conditions. This inspection was overseen by Helen Rawlings, Head of Hospital Inspection.

During the inspection, we visited Hunter, Chatsworth, Evitt, Andrew Reed and Cathcart Wards, and the Jack Emerson Centre (ventilator unit). We spoke with 25 staff including; registered nurses, health care assistants, therapists, administrative staff, medical staff, and senior managers. We spoke with one patient and one relative. We reviewed 13 sets of patient records.

Long term conditions

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long term conditions safe?

Safeguarding

- Staff understood how to protect patients from abuse, and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Junior staff told us they immediately escalated concerns to senior staff. Any incident deemed to be a safeguarding issue was reported to the local Adult Safeguarding team. Through our engagement with the provider, we saw that senior leaders made appropriate referrals to the local Adult Safeguarding team, and worked co-operatively with them to protect patients from abuse. Senior leaders maintained oversight of safeguarding across the hospital through the Safeguarding Awareness Committee, which was chaired by the director of nursing, and reported to the board.

Cleanliness, infection control and hygiene

- On our last inspection, we identified that the provider needed to improve standards of hand hygiene. On this inspection, we viewed hand hygiene audit results for the last 12 months for 13 wards across the hospital. These showed varied results. For example, in May 2018, the highest score was 94.4%, and the lowest score was 55%. Four wards achieved a score of between 90% and 94.4%, which met the hospital's target of 90%. By contrast, three wards scored 80% and above, and the remaining five scored less with one not completing and one scoring 55%. Although these results were mixed, this was an improvement on our last inspection, where no ward result was higher than 60%.
- The RHN provided us with information which stated they were reviewing when and how hand hygiene audits should be completed. Matrons had begun a process of training and standardisation for staff who completed hand hygiene audits, due to an inconsistent approach to assessing hand hygiene across the wards. Leaders had also introduced a peer review system, where staff completed hand hygiene audits on other wards, to give a more balanced picture of hand hygiene practice.
- Staff decontaminated their hands in line with the World Health Organisation's Five Moments of Hand Hygiene. On our inspection, we saw staff washing their hands before, during and after caring for patients.

Assessing and responding to patient risk

- Overall, staff knew how to assess and respond to patient risk and could explain the processes for doing so. Staff identified and responded to changing risks to patients through a multidisciplinary approach. All staff we spoke with could tell us in detail what observations might indicate that a patient was unwell. Staff told us the action taken for a particular patient would depend upon their specific care plan, but generally if nursing staff became concerned about a patient's health or clinical observations they would escalate this to medical staff. Nursing staff told us they used the Situation Background Assessment Recommendation (SBAR) tool when communicating with medical staff about a patient. Nursing staff could explain the action they would take to care for a deteriorating patient. However, staff could not tell us if there was a policy they could refer to which instructed them to take the action they described.
- Medical staff conducted a daily ward round from Monday to Friday. Medical staff told us that if any patient was acutely deteriorating, they would first act

to stabilise the patient, then treat the condition, avoiding transfer to the acute setting where possible. The hospital had a service level agreement with the local NHS acute trust to refer patients, if they became unwell and needed treatment in an acute hospital.

- Prevention, identification and management of pressure ulcers was generally well managed. Senior leaders told us that on admission to the RHN, patients had an assessment using a skin care bundle, which included the use of a nationally recognised risk assessment tool. The individualised skin care bundle was monitored by the patients' multi-disciplinary team, and overseen by the tissue viability nurse for the duration of the patient's stay at the RHN. If a patient developed an area of pressure damage, staff completed an electronic incident report, including photographs of the affected area. This incident report triggered a referral to the tissue viability nurse, who reviewed the patient within 24 hours and provided guidance for staff on the care needed. This process was corroborated by staff we spoke with on the inspection. Following the inspection, the provider told us the TVN reviewed all pressure area risk assessment scores and this was good practice.
- Despite this good practice, recording of key clinical interventions in patient care records was inconsistent. This meant there was a risk that patient care records were not always accurate, which could result in patients not having their care needs met, particularly by new or temporary staff who were not familiar with the patient.
- We found three patient records where the patient had a high-risk score for developing pressure ulcers, but there were no escalation notes on the assessment document. In one of the three records, the patient had a very high-risk score, but staff were unable to locate the associated skin care bundle. There was no policy regarding escalation of risk scores. The provider told us that the pressure area care patients received was part of a care bundle and was regularly reviewed, therefore a change in a patients' score would not necessarily result in a specific escalation, or change in pressure area management. Any changes would be entirely individualised and this approach supported the knowledge and expertise of ward and tissue viability staff and met patients' needs. This explained why the provider did not have a policy on escalation of risk scores. However, in the records we reviewed, staff had not recorded their decisions on caring for patients with high scores, and key information on skin care (the skin care bundle) was not always available.
- Completion of turning charts was also inconsistent. Turning charts covered the 24-hour period. On Chatsworth and Andrew Reed Wards we looked at three patient care records and found completion of turning charts was inconsistent during the day. Staff explained they turned patients as indicated in their care plan. We asked staff about completion of turning charts. One member of staff told us they did not complete patient turning charts during the day, and another member of staff said they did not have turning charts, but had guidelines. This meant that not all staff were clear on their responsibilities to complete turning charts.
- Senior leaders told us that staff did not fill in turning charts whilst patients were sat out in their wheelchairs in the day time, which partly explained the inconsistent completion of turning charts during the day. However, senior leaders acknowledged that staff were not as vigilant in recording when some patients returned to bed from 4pm due to seating tolerance, and when patients were turned thereafter. Senior leaders told us they would address the issue of documentation with staff, through additional education and the outcomes of this would be measured through relevant audits.
- Patients were assessed using the National Early Warning System (NEWS). We viewed the hospital's Adult National Modified Early Warning Score (NEWS) Policy, and saw that it was up to date, and clearly outlined the roles for specific staff. However, we looked at three NEWS records in detail and found that two of the records did not contain escalation notes where scores had triggered. This meant that it was not clear what action staff had taken in response to the triggers.
- Managers conducted monthly NEWS audits. Senior leaders were aware of the lack of compliance with NEWS, and gave examples of when they had identified examples of poor compliance, and provided additional education to the staff members involved.

- We also found one instance, out of four records we looked at, where a patient's fluid balances were not monitored systematically, as fluid balances had not been added up on the patient's chart. Totalling fluid balances is important to ensure that patients are optimally hydrated, and to help staff identify any imbalance. This was action we told the provider they should take to improve at our last inspection. We highlighted this to staff on our inspection, who corrected the lack of totals. However, it should be noted that this was an improvement on our last inspection, where we found we did not find any charts where scores had been added up. Following the inspection, the provider told us they had introduced a multidisciplinary Fluid and Hydration Group (FHG) aimed at improving the completion of fluid balance charts across the hospital.
- The hospital had improved training for ward staff on the risks to patients and residents of not following the guidance for eating and drinking, which was action we told the provider to take at our last inspection. The hospital had placed significant focus on improving staff knowledge of dysphagia (swallowing difficulties). The hospital had introduced a mandatory e-learning module on dysphagia and safe oral intake which staff were required to complete annually, to reinforce the dysphagia training staff received on their induction. The hospital had increased the number of staff completing the dysphagia 'Mealtime Refresher' training to 123 staff as of April 2018, which was above the hospital's target of 90 staff. Staff who received training included nurses, healthcare assistants (HCAs), and therapists. Leaders had worked with the employers of temporary staff working at the hospital, to ensure all temporary staff had access to dysphagia training at least annually.
- The hospital had introduced the role of the dysphagia champions (also known informally as mealtime leads). Dysphagia champions were HCAs responsible for educating and supporting permanent and temporary staff on each ward at mealtimes, focussing on patients and residents with dysphagia. There were at least two dysphagia champions on each ward who were trained in 22 competencies by the speech and language therapy service, which were assessed in a formal competency assessment. We spoke with two dysphagia champions who provided explanations of their roles which reflected the hospital's description, and confirmed they had received training and support. Other staff we spoke with understood the role of the dysphagia champions, and felt the role was a positive initiative. The work of dysphagia champions was overseen by specialist speech and language therapists, who were the hospital's primary source of expert advice.
- We saw key patient risks to be aware of during mealtimes, such as choking and allergies, were highlighted on the patient's meal mats and in their care plan.

Records

- Staff kept paper records of patients' care and treatment, and these were easily available to all staff providing care. However, records were not always consistently detailed or completed as required, which meant there was a risk that there may not be an accurate record of the care patients had received, and patients might not have their care needs met as a result. This is discussed in more detail above, under assessing and responding to patient risk.
- We spoke with two members of staff about documentation, and both told us that they did not always have time to complete patient care records thoroughly. Managers were aware of this, and explained that care records would usually be completed in the afternoons, but it depended on how busy the ward was. This meant that if the ward was busy, staff might not have been able to complete an accurate record of patient care they had delivered.
- Senior leaders were also aware that there was a lack of consistent documentation across the specialist nursing home, and managers conducted weekly audits of care records. To mitigate the lack of consistent documentation, a pilot project had been introduced on Glyn Ward, where a checklist sticker could be placed in the record. The sticker would enable staff to document key clinical interventions quickly, although staff were still required to write free text where appropriate. Leaders told us the hospital was in the process of rolling out the use of the sticker through the Specialist Nursing Home. Nevertheless, we did not see the sticker in use in the records we looked at.

Long term conditions

- The service had made improvements in ensuring that residents of the specialist nursing home had all aspects of their care plans reviewed in line with national practice. Care plans were scheduled to be updated every three months, and this was overseen by ward managers and matrons. We looked at 13 care plans, and saw that most were dated within the last three months. This was an improvement on our last inspection, where some residents in the nursing home had not had all aspects of their care plans updated in more than a year.
- Patient care plans mostly included important information needed for staff to deliver safe care and treatment. Key risks to patients, such as allergies, were highlighted on a sheet at the front of care plan folders. We looked at 13 patient care plans and saw that these were clear, mostly up to date, and covered key aspects of patient needs and risks. Where patients were unable to communicate their wishes, care plans had been signed by the patient's relative or someone close to them, to confirm that they had the opportunity to contribute to the care plan and they agreed with its content.
- Volunteers documented when they took patients to leisure activities and when they returned to the ward, on separate paperwork to that of their case notes.

Incidents

- Staff understood their responsibilities to raise concerns, record safety incidents and near misses, and to report them internally and externally, where appropriate. Staff reported incidents on an electronic system. Incidents were audited and analysed by the Patient Safety and Quality Team, which ensured senior leadership oversight of incidents.
- When incidents occurred, the Patient Safety and Quality Team had an initial discussion, and assigned the incident to a member of staff to investigate. Senior leaders told us they would choose a member of staff who had not been involved in the incident, and had received root cause analysis (RCA) training, where appropriate. An RCA is a systematic process of analysis whereby the factors that contributed to an incident are identified, so that lessons are learned and areas for change are identified. Staff told us if they needed help with completing an RCA, they would ask a matron, and felt confident they would be supported.
- Learning from incidents was shared amongst staff in several ways, which varied from ward to ward. There was a hospital-wide 'lessons learned from clinical incidents' meeting every month, and each ward sent a representative to attend. Staff we spoke with could give examples of recent incidents, including remedial action taken. Some wards held their own 'lessons learned' sessions once a week, where they would go through an incident in detail. Key points from the 'lessons learned' session would also be highlighted to staff during handovers. We saw that any incidents that had occurred on the previous shift were recorded in the ward diary, which every member of staff checked prior to starting their shift.

Safety Thermometer

- Between June 2017 and June 2018, the RHN reported 21 new pressure ulcers, two falls with harm, nine new catheter-acquired urinary tract infections and seven new instances of venous thromboembolism (blood clots). This was a low level of incidents of this kind. The Jack Emerson Centre (ventilator unit) reported the highest number of pressure ulcers, with 14 of the total 21 reported by the provider. The Jack Emerson Centre was part of the specialist services, separate to the specialist nursing home. Therefore, as two thirds of new pressure ulcers were reported in the Jack Emerson Centre, this indicated that there were few pressure ulcers reported in the specialist nursing home.
- The provider reported that between June 2017 and June 2018, an average of 98.6% of patients received harm-free care. This was better performance than the national average, and slightly improved from 97.6% at the time of our last inspection.
- Safety thermometer data was clearly displayed on the wards we visited.

Are long term conditions effective? (for example, treatment is effective)

Nutrition and hydration

- The provider had updated mealtime guidance to include new titles for foods and textures to make it clearer to staff what each one meant. This helped staff to ensure that each patient received the right food or drink according to their needs. We viewed the oral food and drink guidelines on the hospital shared drive and saw that this was up to date.
- Each patient had a personalised meal mat. Meal mats were laminated with quick reference guides to patient needs, risks and preferences for eating and drinking. Mats were kept with the patient whilst they were supported during mealtimes. Meal mats showed the food and drink patients could consume, including detailed information on texture. Meal mats also documented the correct position patients for eating and drinking (as advised by therapy staff), level of help required, and communication. We looked at three meal mats and saw that these were all personalised, with patient photographs and were all dated within the last six months prior to our inspection.

Competent staff

- On this inspection we found the provider had made improvements to appraisal rates. Annual appraisals were conducted from September to October. As of 7 March 2018, the Individual Performance Review (IPR - the provider's term for appraisal) completion rate for eligible staff at the RHN was 95.5%, meeting the 95% target. Staff we spoke with were positive about IPR, and told us they participated in setting their objectives, and were supported in completing them.
- Staff were supported and managed to deliver effective care and treatment. Staff told us they could access one-to-one meetings and clinical supervision and these were useful. The hospital had also recently held a 'caring' awareness day focusing on respiratory and skin care. Leaders told us this was aimed at nursing staff to generally raise awareness of these topics and make sure staff knew the resources that were available to them. We viewed the agenda for this awareness day and noted the sessions were repeated at intervals throughout the day, and there were 'drop in' sessions, to enable more staff to attend.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with mostly understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. The RHN had introduced MCA mentors, who could provide support and advice for staff. At the time of our inspection, there were nine MCA mentors across the RHN.
- We saw there was information available for staff, patients and relatives throughout the hospital which provided clear explanations of the key principles of the MCA and Deprivation of Liberty Safeguards (DoLS).
- Training for staff, on the different degrees and types of decisions patients and residents could make, had been improved. The Clinical Lead for MCA and DoLS now held tailored training sessions on each ward every three months, including discussion of scenarios involving specific patients from the ward. Staff told us this helped them to understand how they could support patients to make decisions.
- Leaders told us they obtained assurance on staff knowledge and confidence in applying the MCA and DoLS through ward training sessions, the RHN mock inspection programme and completion of e-learning.
- On this inspection, we found staff awareness of the need for reasonable adjustments to help patient's decision-making had improved. Staff told us they presumed patients had capacity unless there was evidence to the contrary, and recognised the need to respect patient's rights to make unwise decisions. Staff told us they supported patients to make decisions, such as deciding what clothes to wear. Staff who were 'key workers' for particular patients were knowledgeable of how the patient might communicate with them, for example by blinking, or certain expressions or gestures. Staff were clear that they needed to involve patients in decisions about their care, and where patients were unable to make such a decision, a multidisciplinary best interests meeting would be held, that included the patient's family, or appropriate advocate.
- Patient care plans contained details as to whether a patient was able to make some, none or all decisions for themselves, and when a best interests assessment would be needed. The care plans informed staff how they could support patients to express their wishes, in

the communication section of the care plan. For example, care plans contained instructions for staff to speak to the patient in a clear well-modulated voice, provide time for the patient to understand, and be aware of words, expressions or gestures the patient might use. However, MCA care plans were not always sufficiently detailed. In the records we looked at, where a patient could make 'some' decisions, details of what was meant by this were not listed in the care plan. MCA care plans were reviewed as part of the hospital's programme of mock inspections, but there was no formal audit programme specifically for MCA care plans. Therefore senior leaders could not always robustly monitor MCA care plans. Senior leaders told us they tried to set aside time monthly to look at specific MCA care plans, templates and data, but this was not always possible. At the time of our inspection, there were plans to recruit an additional clinical psychologist and administrator to support MCA and DoLS training, staff competence and record management.

- We noted that some patients' DoLS authorisations (a set of checks which aim to make sure that any care that restricts a person's liberty is both appropriate and in their best interests) had expired and were due for review. However, in all the cases we looked at where a review was due, applications for review had already been lodged with the local authority, who had not yet arranged to conduct the review. RHN staff liaised with local authorities on a regular basis, but ultimately this was outside of the hospital's control. In the meantime, senior managers oversaw existing restrictions, ensuring that they followed the key principles of acting in the patient's best interests and managing any deprivation of liberty in the least restrictive way.

Are long term conditions caring?

This key question was not inspected.

Are long term conditions responsive to people's needs?
(for example, to feedback?)

Learning from complaints and concerns

- The RHN complaints handling process had improved since our last inspection.
- We looked at the RHN's complaints policy and saw that it was up to date, had a clear review date, and explained the specific roles of staff in managing complaints. The policy comprehensively described the processes for managing informal and formal complaints. At the time of our inspection, senior leaders were in the process of updating the policy, to include a section on persistent, vexatious and abusive complainants.
- Through our engagement with the provider, from January 2018 until July 2018, we viewed two complaint responses, which showed a more structured approach to handling complaints. Upon receipt of a complaint, the patient safety and quality team sent out an acknowledgement letter, identifying the investigation terms of reference, to the complainant within two working days. The acknowledgement letter informed the complainant of the latest date they could expect to receive the full complaint response.
- Where possible, managers held an initial meeting with the complainant to discuss their concerns. Notes were recorded of this meeting, and a copy was given to the complainant. A formal complaint response letter was then sent to the complainant, alongside an accompanying investigation document. The complaint letter was structured by addressing each of the complainant's concerns individually.
- The RHN took steps to ensure that complainants were satisfied with the outcome. If the complainant was not happy with the stage one complaint response, they were advised to address the complaint to the chief executive (stage two). Complainants were advised the chief executive would then review the complaint, and either confirm the decisions and actions taken by the original investigator, or reach an alternative decision to help resolve the matter. In both complaints we looked at, the chief executive met with the complainant to discuss their concerns, either prior to producing a written response or afterwards, to discuss care going forward.
- Senior leaders aimed to meet with patients or families who were unhappy wherever possible. There was

system through which patients and their families could make appointments to discuss concerns with medical staff or managers, to prevent escalation of complaints. The RHN also offered complainants the opportunity to have a key contact, who was a member of staff not involved in the patient's care they could go to for advice or support at any time.

- Staff on the wards told us that if patients or their relatives were unhappy about something, they discussed the issue with them in a calm manner, and ask how they could help. Staff told us they would acknowledge the person's complaint, apologise and try to resolve the issue. If this was unsuccessful they would inform the ward manager and signpost the complainant to the complaints team. This approach was underpinned by the section on managing information concerns in the RHN's complaints policy.

Are long term conditions well-led?

Leadership

- Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. Leaders we spoke to could explain issues we had identified, such as inconsistent documentation, without prompting, and had planned a series of audits and awareness sessions to improve this. Leaders expressed a commitment to continuous improvement. For example, the RHN had implemented a 'Putney Nurse' programme (a qualification in neuro-rehabilitation nursing), to boost staff knowledge and retention. There was a similar programme for HCAs, and one cohort had completed the programme so far.
- Staff said leaders were visible and approachable. All the staff we spoke with told us if they had concerns they would feel comfortable to raise them with senior leaders.

Governance

- There were effective structures and systems of accountability to support the delivery of good quality, sustainable services. Each ward within the specialist nursing home was led by a ward manager, who was managed by the Specialist Nursing Home matron. The head of nursing oversaw the work and line management of the matrons. The director of nursing held executive responsibility for nursing. There were separate governance arrangements for allied health professionals and medical staff who worked on the wards.
- The provider had effective systems and processes to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. There was an Organisational Improvement Plan, which fed up from the wards to the board through weekly ward quality audits. These audits included specific targets or goals for each ward to achieve, and involved a review of a sample of patient records. Leaders met monthly with the ward, to ensure the ward was on track to meet the requirements of the audit. If these targets or goals were not achieved, leaders worked with staff to initiate a relevant action plan, and arranged training to improve staff knowledge. Audits were then formally reviewed at board level at the Patient Quality and Safety Committee.

Managing risks, issues and performance

- There were assurance systems at the hospital. Managers escalated performance issues through clear structures and processes. Senior leaders told us key managers met weekly to discuss any serious incidents, complaints, governance and safeguarding issues.
- At the time of our inspection we met with the senior leadership team responsible for continuing care including the matron, head of service and head of nursing. The leadership team were aware of the issues we noted on our inspection and had plans to address most of them.
- We viewed risk registers for the hospital overall and for the specialist nursing home. We found some alignment between issues we had identified on the inspection and what was on the risk register.
- The executive management team reviewed the organisational risk register, which included clinical risks, on a monthly basis. The Audit and Risk Committee and the board also reviewed the organisational risk register quarterly. The Clinical Risk and Incident Committee reviewed the clinical risk

register (which fed in to the organisational risk register) every other month. The Patient Safety and Quality Committee also reviewed the clinical risk register quarterly.

In addition, the senior leadership team reviewed selected aspects of the risk registers every six months, in a 'deep dive' format.

Engagement

- The RHN had access to feedback from patients, carers and staff, and were using this to make improvements. Since our last inspection, the hospital had implemented a programme of mock inspections every six months, with staff, patients and relatives acting as inspectors. We also saw 'you said, we did' displays on wards which showed examples of where action had been taken or improvements made in light of patient or family feedback.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take action to improve the consistency of completion of documentation, particularly recording of key clinical interventions, including turning charts, and NEWs scores.

Action the provider SHOULD take to improve

- The provider should continue to improve standards of hand hygiene.
- The provider should ensure that where it is stated on a patient's MCA care plan that they can make 'some' decisions, there are clear details of what is meant by this.
- Continue work to ensure that patients' fluid balances are monitored systematically by adding up fluid balances on charts.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance** **Patient records were not always consistently detailed or complete.** • **Recording of key clinical interventions such as completing turning charts, and escalation of NEWS scores, was inconsistent.** • **Staff told us that they did not always have time to complete care records thoroughly.** Regulation 17 (2) (c)