Active Neuro Limited

Frenchay Brain Injury Rehabilitation Centre

Inspection report

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

Ratings

Overall rating for this location	Insufficient evidence to rate
Are services safe?	Insufficient evidence to rate
Are services effective?	Insufficient evidence to rate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Insufficient evidence to rate

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service had persistent challenges with recruitment and relied on agency staff to maintain the service, particularly out of hours. There were significant challenges and risks around this, which resulted in a deterioration of service for patients and their relatives during these times.
- Training completion rates for positive behaviour management, which was an important to maintain safety, were low and required immediate improvement.
- While staff managed incidents well, the categorisation and investigation of incidents was questionable, which meant learning and mitigation did not always receive adequate focus. This created a risk of future incidents that could potentially be avoided.
- While managers monitored the competence of substantive staff, there was no similar assurance for agency staff. Completion rates for positive behaviour management training did not meet safe standards.
- Patient records overall were of a good standard but there were inconsistencies such as missing Waterlow documentation and varying practice in managing pain scores.
- Fire safety records did not provide assurance of consistent standards of practice.

However

- Staff had training in most expected key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and adhered to them when delivering care. Staff managed medicines well.
- Staff mostly provided good care and treatment, checked that patients ate and drank enough, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. The service offered a referral to admission time that was better than comparable services in the region.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Requires Improvement 	We rated this service as requires improvement because it was effective, caring, responsive, and well led although some areas of safe requires improvement.

Summary of findings

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Summary of this inspection

Background to Frenchay Brain Injury Rehabilitation Centre

Frenchay Brain Injury Rehabilitation Centre, known locally as BIRU, provides a regional rehabilitation service for adolescents and adults with a brain injury. Care is provided for a range of acquired neurological conditions such as traumatic brain injury, sub-arachnoid haemorrhage, complex stroke, anoxic injuries, and infection-related injuries such as meningitis and encephalitis.

Located within the grounds of the former Frenchay Hospital in Bristol, the service specialises in the treatment of individuals with complex physical and cognitive impairments, challenging behaviours and neuropsychiatric disorders resulting from a brain injury.

The residential service has 52 beds split over two buildings, Frenchay BIRU South and Frenchay BIRU North. Each building is divided into three wards. Some bedrooms include private showers, and all include private toilet and sink. The service categories beds using NHS England (NHSE) guidance for people with a brain injury. It has 29 beds for patients needing intensive rehabilitation care, which NHSE define as level one. The service has 23 beds for level two patients, who need rehabilitation care. NHSE levels relate to the level of clinical acuity and need of each patient.

The service is registered with CQC to provide the following regulated activities:

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

A registered manager is in post.

We last inspected the service in October 2018. We rated safe and well-led as requires improvement and rated effective, caring, and responsive as good. We rated the service requires improvement overall. At that inspection we told the provider they must improve:

- The storage of chemicals subject to the Control of Substances Hazardous to Health (COSHH) Regulations
- The monitoring of resuscitation trolleys
- Staff knowledge of the national early warnings scores system (NEWS2)
- Secure storage of confidential records.

At this inspection we found the service had improved all four areas and these were no longer of concern.

How we carried out this inspection

We carried out an announced inspection of the service on 25, 26, 27 October 2022 and 5 November 2022 using our comprehensive methodology. The inspection team consisted of a lead inspector, a second inspector, a specialist advisor, and an inspection manager. During our inspection we spoke with staff, observed care being delivered, and reviewed audits and other clinical records.

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

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- Staff worked tirelessly to identify and act on the latest research and evidence-based practice in international rehabilitative care. Staff at all levels were empowered to review research and suggest trials and pilot schemes and senior staff supported staff to develop such work. This resulted in standards of care at the leading edge of international practice, which the service shared through knowledge networks and platforms such as at conferences and with accrediting organisations.
- There had been a substantive improvement in emotional and wellbeing support for staff. This included an innovative emotional support tool, connected to patient's needs, that helped the senior team identify where staff may require additional support to maintain their wellbeing. This is one example of a broad range of staff-led initiatives that reflected very high standards of engagement, emotional intelligence, and effective leadership.
- The therapies team developed an intensity of practice project, which used new research to restructure the intensity of therapy as a strategy to improve outcomes and patient experience. This was a fully formed trial in which staff and patients were involved in a cycle of testing and feedback despite the significant pressures on the service.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure all staff, including agency staff, support patients to maintain relationships with people important to them consistently, including at weekends (Regulation 10)
- The service must implement specific risk assessments and staff training for patients who express suicide ideation (Regulation 12)
- The service must improve operational knowledge and competencies of agency staff to support the substantive team out of hours and during medical emergencies (Regulation 12)
- The service must urgently prioritise the completion of up to date PBM training for all relevant staff (Regulation 12)
- The service must improve the investigation process of incidents to support learning and reduce future risks (Regulation 17)
- The service must improve overall standards of record-keeping in relation to the consistency of waterlow scores, pain scores, and use of body maps for skin integrity (Regulation 17)

Action the service SHOULD take to improve:

- The senior leadership team should consider how the incident monitoring and investigation system can be used to track incidents by time and shift to better understand levels of risk.
- The service should continue to improve training for safe fire procedures.
- The service should ensure staff maintain good standards of personal hygiene at all times.
- The senior leadership team should consider standardising the skill mix of nursing staff across shifts to support consistent standards of quality care.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate

Requires Improvement

Community health inpatient services

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff although completion rates of practical training needed improvement.

Staff were required to maintain a programme of mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. At the time of our inspection 94% of staff were compliant with e-learning requirements and 62% were compliant with practical training requirements. Practical training included life support, positive behaviour management (PBM), and safeguarding. The hospital director had scheduled a training plan that aimed to improve practical training compliance to 89% by the end of 2022.

Staff spoke positively about training and said they felt well prepared to meet patient's needs.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. They completed appropriate training for patients being cared for under a section of the Mental Health Act.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were required to maintain a minimum overall compliance of 75% with mandatory training to be able to work with patients.

The completion rates for nationally mandated positive behaviour management (PBM) training was 50%. Five staff had been accredited as trainers and a further two staff were progressing with the course. The hospital director recognised this as a priority and had arranged for trainers to deliver courses for nightshift staff. Ward managers allocated staff with PBM training to patients known to present a need for restraint. This meant agency staff were not allocated to such patients. However, there remained a risk as staff without the most recent training update could be required to restrain patients in an urgent situation.

All staff held up to date basic life support (BLS) training. Nurses and registered health professionals held immediate life support (ILS) training and all were up to date with required updates and refreshers.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All clinical staff maintained safeguarding level three training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Care plans included evidence of discussions with patients and their families about providing good care in adherence to expectations around culture, religion, sexual identity, gender identity, and age.

Staff knew how to identify patients at risk of, or suffering, significant harm and worked with other agencies to protect them. They worked with other bodies to support good safeguarding practices, including police and social services.

The hospital director was the safeguarding lead and was trained to level four. The matron, head of therapy, and both deputy matrons were also trained to level four, which reflected high standards of practice of safeguarding.

The team demonstrated good practice when supporting a patient with complex mental health needs being treated under a section of the Mental Health Act. They worked with multidisciplinary teams and appropriate protection agencies to ensure the patient was safe and protected from harm following allegations of abuse.

Community care coordinators liaised with community safeguarding teams to prepare for patient's discharge and ensure they had effective care systems in place.

Staff followed safe procedures for children visiting the wards and maintained child safeguarding level two training.

A senior member of staff audited safeguarding practices quarterly. This included a review of safeguarding referrals, a sample of case tracking, and the timeliness of staff response to risks. Audit data from the most recent six months found consistently good standards of practice, with over 99% compliance with expected standards.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Ward and therapy areas were clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness and a dedicated housekeeping team monitored cleaning standards using checklists and audits. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Most staff followed infection control principles including the use of personal protective equipment (PPE). We saw consistent standards of handwashing amongst staff in between patient contact or administrating medicine and good

standards during a medical emergency. During our observation of a meal service, staff did not follow good hand hygiene practices. They did not wash their hands before supporting patients with meals. One member of staff arranged their hair in front of the hot food trolley, donned gloves, then continued to arrange their hair. They then served food without gelling their hands. This reflected poor hygiene practice.

Staff audited hand hygiene practices through a random monthly sample of observations. The most recent monthly resulted found 86% compliance with expected standards.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Although the services reported infections related to COVID-19 to external agencies in the previous 12 months, there were no infections relating to meticillin-resistant *staphylococcus aureus* (MRSA), c*lostridium difficile* (*C.difficile*) or norovirus. The service maintained an isolation room that could be used to treat an infectious patient. Staff audited compliance with policy on safe catheter care and demonstrated a good track record, with 100% compliance in the previous six months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care, staff took precautions and actions to protect themselves and patients.

Patient bedrooms were equipped clinically based on their level of need, as defined by NHS England. All bedrooms had toilets, hand washing sinks, a laundry basket, a comfortable chair, a wardrobe, and a chest of drawers. Over 50% of bedrooms had a private shower. Where patients shared a shower, staff facilitated same-sex facilities.

Patients could reach call bells and staff responded quickly when called. The senior nursing team used a call bell audit to monitor staff response times and the most recent data reflected good standards of practice.

The design of the environment followed national clinical guidance. Patient bedrooms were equipped based on individual needs and level of acuity. Rooms for intensive rehabilitation patients had more space to manoeuvre mobility equipment and an overhead hoist.

Staff carried out daily safety checks of specialist equipment. An on-site maintenance team provided support and the service used a system of planned preventative maintenance to keep equipment in good condition. All equipment we checked had an up to date service and electrical safety test.

Staff were proactive in implementing new contingency plans as learning from equipment failure. For example, the hydrotherapy pool closed temporarily after chlorine deterioration caused safety straps on equipment to snap. The lead physiotherapist implemented new processes to avoid a repeat by keeping a greater stock of replacement straps and implementing weekly stress testing to check for deterioration.

Staff managed, streamed, stored, and disposed of clinical waste safely and in line with national guidance. The service was compliant with Department of Health and Social Care guidance and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.

One area of a ward was equipped for segregation. Staff used this to accommodate patients at significant risk of self-harm, or who presented a risk to the safety of others. When in use for segregation, the area was secured and included a bedroom, lounge, and outside courtyard. This area was rarely needed and had not been used in the previous two years.

Resuscitation equipment was located in clinical areas. Staff documented daily and weekly stock checks to ensure the equipment was ready for use.

Risk assessments were in place for ligatures and staff audited the environment periodically to check for safety and risk management. The most recent audit found good practice, with staff aware of patients at increased risk and a good system in place to reduce ligature points. The service had six dedicated ligature-free rooms used for patients with the greatest risk.

The service carried out monthly fire drills, which involved evacuation, quarterly and the senior team assessed staff response to identify standards of good practice and areas for improvement. Recent fire drills highlighted a need for improved practice. In one fire drill, agency staff returned to the building while the alarm was sounding. In another drill, evacuation was delayed because there were no defined roles amongst the team on duty.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used the national early warning scores (NEWS2) tool to identify deteriorating patients and escalate them appropriately. Nurses countersigned NEWS2 scores to ensure accuracy, which reflected improved practice following our last inspection. Staff audited use of the NEWS2 tool monthly. The most recent audit result demonstrated 71% compliance with expected standards. The hospital director recognised the need for improvement and had implemented additional training and support for staff.

Staff acted quickly to obtain emergency medical support when patients deteriorated. We saw evidence staff were responsive when patient's behaviour or needs changed and they escalated care appropriately, which reflected high standards of training. Staff kept patients safe during extended delays for an emergency ambulance. They monitored vital signs and continuously reported changes in the patient's condition to the 999 service.

Escalation pathways were well established, and all members of staff were trained to use them. For example, nursing technicians escalated deteriorating patients to the nurse in charge or doctor on call and began neurological observations.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after an incident. For example, staff increased the frequency of observations when a patient's vital signs or needs changed, such as moving from 12 hourly observations to two hourly when a patient's temperature increased unexpectedly.

Staff used specific risk management plans for conditions such as epilepsy. This included staff training, rescue medicines, and consideration of psychological factors that may trigger or exacerbate the condition.

Requires Improvement

Community health inpatient services

Staff knew about and dealt with specific risk issues, such as falls, skin integrity, choking, venous thromboembolism, and mood. They assessed patients for falls risk at regular intervals and clearly labelled records and bedroom doors to note the risk using a discreet system that protected dignity whilst alerting staff to the risk. Staff audited falls risk assessment monthly and found consistently good standards of practice. For example, staff involved patients in their own risk assessments to help identify the best mitigating factors.

While most risk assessments were comprehensive, there were inconsistencies in some documentation. For example, three patients had lengthy gaps, of up to three months, in the documentation of waterlow scores. Waterlow scores identify the risk of pressure ulcers based on factors such as age, weight, and skin type. We spoke with two members of staff about this who said they often carried out assessments such as this but did not always document it. However, the most recent audit of pressure ulcer management indicated 100% compliance with expected standards. The audit included a sample of 25% of records in line with the quality assurance framework, which suggested generally good practice with some areas for improvement as reflected by our own checks. The difference between our findings and the audit results meant quality and assurance checks were not always effective.

Nurses and therapists undertook training to help them respond to patients who behaved sexually inappropriately, including when they were aggressive. The service had clear guidance for staff, who reported such occurrences as an incident that the behavioural team then investigated.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. This included an on-call psychiatrist through an arrangement with the local NHS trust's 'hospital at night' service.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw good standards of practice in documenting risk and identifying triggers for a patient at risk of self-harm and suicide attempt but very limited evidence of structured risk assessment. For example, one patient was known to be at risk of suicide ideation, but notes were convoluted and did not provide a straightforward picture of assurance that staff were managing risk. Staff had not undertaken specific training to manage suicide risk but said they felt confident in this area from their mental health training.

Staff shared key information to keep patients safe when handing over their care to others and shift changes and handovers included all necessary key information to keep patients safe. However, staff who started their shift outside of the main handover times did not always receive good briefings. For example, one member of staff who joined a shift at lunchtime did not know who was on shift or about any specific risks or activities on the shift. The hospital director told us handover processes were being improved.

The senior team audited medical emergency response practices monthly to assess the standard of care for patients who deteriorated and the consistency of the NEWS2 system. The audit included appropriate use of 'do not attempt resuscitation' (DNACPR) documentation and practices, management of emergency medicines, the level of staff training, and evidence of post-incident support for staff. The most recent audit identified good practice, with between 85% and 100% compliance with expected standards.

Nurse staffing

Requires Improvement

Community health inpatient services

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix but a reliance on agency staff reduced the quality of service provided.

The service had enough nursing and support staff on each shift to keep patients safe. However, this was achieved through staff working additional hours and a high use of agency staff, which meant there were not enough substantive staff overall. At the time of our inspection the service had a 20%registered nurse vacancy rate and a 31%rehabilitation assistant vacancy rate.

Ward managers, who were senior nurses, led each shift. During weekday daytimes, the senior leadership team provided support. Out of hours, ward managers were the most senior staff on site. During our out of hours inspection it was not evident this level of seniority was effective to manage the service safely. After our inspection the hospital director and their senior colleagues took immediate action to address the issues and implement improved ways of working.

The service reported persistently high turnover rates, which reflected 30% of the workforce in the previous year. The registered manager had implemented a recruitment plan in response to a challenging workforce environment.

Managers accurately calculated and reviewed the number and grade of nurses and rehabilitation assistants for each shift in accordance with national guidance. The service reported a fill rate of 84% for nurses and 68% for rehabilitation assistants.

Nine occupational therapists, nine physiotherapists and eight speech and language therapist formed the allied health professional team with support from rehabilitation assistants and therapy assistants.

The hospital director held consistently good standards of recruitment records that met national requirements. These included qualifications, appropriate references, and evidence of identity checks. The service renewed each member of staff's disclosure barring service (DBS) criminal background check every three years.

While agency staff had an induction to the service, this was not always effective. During one day of our inspection we found some agency staff unfamiliar with their surroundings and with limited access to key areas of the building. After our inspection, the hospital director implemented a plan to address this.

While ward managers planned staffing levels in advance, overall vacancies meant there was no contingency in place for emergencies. Staff said they were left short staffed when colleagues accompanied patients to hospital in urgent situations. We saw this in practice during our weekend inspection. Substantive staff dealt quickly and appropriately with a medical emergency, prioritising the patient at risk of harm. However, the remaining staff could not provide an acceptable level of care and service to other patients and their visitors. After our inspection the hospital director worked with their team to implement a new response protocol that meant there would always be substantive staff available for the rest of the hospital while others attended to an emergency.

Staff described staffing as a persistent challenge and said they regularly felt short of nurses and rehabilitation assistants.

Staff described significant challenges during shifts staffed with high numbers of agency colleagues. They told us each shift required them to take time away from patients to explain local processes to agency staff. One member of staff said weekend shifts were difficult because they had to "pick up the slack" from agency colleagues. The nurse in charge was always a substantive member of staff who allocated roles based on experience, which aimed to ensure the skill mix of agency staff reflected patient need.

Staff told us agency colleagues they worked with often had no experience working with patients with brain injuries and that their behaviour often triggered distress in patients. During our weekend inspection we found wide variances in the standards of work amongst agency staff. We spoke with the hospital director about this and they implemented a plan to improve standards by working with their counterparts in agencies to supply the same staff consistently and focus on them for training and development.

As part of learning from an incident, the service had introduced a reduced staff risk assessment. This guided the team in prioritising patients at the greatest risk for constant supervision and ensured other patients received timely checks in line with their needs.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Each patient was assigned a consultant on admission and a team of clinical fellows supported the delivery of care and treatment.

A team of clinical neuropsychologists worked with consultants to improve psychological wellness and assess and treat cognitive problems. The service had two full time clinical neuropsychologists and one full time vacancy. Three assistant psychologists provided support.

Managers could access locums when they needed additional medical staff and made sure they had a full induction to the service before they started work.

Overnight and at weekends the service had a service level agreement with a nearby NHS trust to provide a 'hospital at night' service, which gave staff access to medical review.

Records

Staff kept records of patients' care and treatment although these were not always completed consistently. Records were clear, stored securely and easily available to all staff providing care although there were gaps in consistency.

The service used a national electronic patient records system that failed for all providers in August 2022 due to a cyberattack. This meant the service had to quickly transition to a paper-based notes system. Staff had worked hard to adapt to the new system with the additional challenge that some historic records could not be accessed.

Patient notes were comprehensive, and all staff could access them easily. Staff documented detailed multidisciplinary records of daily care that were person-centred and focused on the patient's recovery goals. Three records we reviewed

had missing items, such as gaps in waterlow scores. Staff told us they did not always document assessments, such as waterlow and pain scores, which meant records were not accurate and contemporaneous. After our inspection the hospital director provided evidence of a new records management system that would help staff to structure the records more consistently.

When patients transferred to a new team, there were no delays in staff accessing their records. During emergency transfers staff prepared the most vital records to accompany the patient. Discharge coordinators prepared copies of records for patients on discharge and shared these with their onward care providers.

Physiotherapists used an electronic tool to document exercise plans and record progress. The tool included videos of exercises, which patients and other teams could access themselves to support activities outside of formal therapy sessions.

The hospital director audited records, care planning and risk assessments using a monthly sample of patients. The most recent data available related to August 2022 and found variable results, with between 60% and 85% compliance with expected standards.

Staff maintained a patient support summary in each individual's bedroom. This included details of mobility and risk assessments and records of personal care needs.

Records were stored securely in locked areas with restricted access.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. They reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. Treatment rooms were electronically locked with controlled access and temperature controls in place. Staff used an effective stock management system that ensured medicines were always within their expiration date. Staff monitored the temperature of areas used for ambient and refrigerated medicines to ensure medications were stored within the safe range of manufacturer guidance.

Registered staff managed Controlled Drugs in line with national legislation. This included double-locked storage and dispensing checks signed by two members of staff. All the records we checked followed this standard.

Doctors reported medicine errors centrally to the provider, who monitored this across all locations. They implemented the Duty of Candour when needed, such as when an 'as needed' (PRN) medicine was administered against a patient's best interests decision care plan. They investigated such incidents and shared learning with the whole team.

The service contracted an external pharmacy to manage medicine ordering, delivery, and documentation. A pharmacist carried out a weekly audit of medicines, including a review of patient's medicines charts and errors.

Doctors managed to take away (TTO) medicines for patients leaving the service and organised this with the pharmacy team.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. On admission doctors became responsible for all the patient's medicine, include their usual prescriptions. Doctors worked with the pharmacy team to ensure overall prescriptions were appropriate and proportionate.

Staff had access to a rapid tranquilisation kit and undertook training with the behavioural team around its safe use. Staff used this kit in the event violent behaviour from a patient put others at risk of harm. A consultant carried out a best interests assessment prior to staff tranquilising a patient and if it was used in an emergency without prior planning, consultants led a review of the positive behaviour management techniques used.

Incidents

The service generally managed patient safety incidents well although categorisation and tracking of incidents meant future risks were not always mitigated.

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Substantive staff knew what incidents to report and how to report them although agency staff did not have access to the reporting system. This meant they needed to liaise with a substantive colleague to submit a report.

Monthly incident reports varied in number and in the previous six months ranged from 63 in September 2022 to 98 in August 2022.

Staff raised concerns and reported incidents, including serious incidents, and near misses in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The provider had clear guidance on the use of the duty of candour and the hospital director documented when this was used.

Staff received feedback from investigation of incidents, both internal and external to the service, although staff we spoke with were not consistently aware of outcomes.

There was evidence that changes had been made as a result of feedback. For example, the hospital director identified through the quality assurance framework, a process required implementing post chemical restraint, if it was to be used. They included changes in the service improvement plan and were working with staff involved in each incident to ensure such methods were always essential.

Managers investigated most incidents thoroughly. Patients and their families were involved in these investigations. While senior staff investigated incidents there was limited analysis of incidents tracked by time. This meant the team could not identify themes whereby incidents occurred during certain shifts or when certain factors influenced risk, such as shifts with staffing pressures.

Requires Improvement

Community health inpatient services

We were not assured the incident investigation system was effective in consistently and effectively categorising incidents and subsequently recognising risk. For example, where staff categorised risks as having minor harm, there were limited actions to prevent future recurrence. This meant learning from incidents such as choking was not fully realised. Similarly, the service did not map incidents to shift times, such as weekends when there were fewer substantive staff on shift. This meant the service was not assured of knowledge of pressure points with increased risk at certain times of day.

Some incidents we reviewed had not been appropriately investigated, and the associated learning and emphasis on mitigation of risk was missed. We reviewed eight incidents and found gaps in the scope of investigations and identification of learning. Two incidents had potential to result in serious injury or death, but the investigation had not identified appropriate learning that could be used for future prevention. Lessons were not learnt or shared, and the risk of repeat occurrence prevailed. For example, when a patient scalded themselves from a hot drink and another patient choked on food, staff responded quickly to provide first aid. However, there was no evidence they carried out an assessment to identify the cause of each incident, which they documented as accidents. This meant there was no learning based on the individual risks of those patients. We spoke with the registered manager about this who arranged for the incidents to be reviewed again through the governance system and by an external specialist. This found staff had used the provider's incident management system correctly, but the lack of appropriate learning and outcomes indicated a need for improved processes.

Incident reports were clear, concise, and useful for leaders in understanding the nature of incidents. Use of the reporting system highlighted a healthy reporting culture that helped to identify themes, such as medicines errors, and patient behaviour.

The hospital director was working with the team to better understand incidents that occurred with patients who received one-to-one enhanced care. For example, staff reported 10 patient falls in September for those who received enhanced care and it was not clear if there was a theme between them.

Managers debriefed and supported staff after any serious incident and on request by staff.

Staff reviewed national safety alerts in daily flow meetings and ensured any changes to practice or policy were communicated to the whole team. The senior nursing team tracked safety alerts to ensure they were implemented by the whole team.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Requires Improvement

Community health inpatient services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to electronic policies and procedures and the monthly clinical governance audit provided assurance of this through spot-checks with staff. The most recent audit found all five members of staff checked could demonstrate full access.

The care model was evidence-based and reflected the latest understanding of effective care for patients with brain injuries receiving residential rehabilitative care. Staff reviewed this regularly to ensure it reflected the latest understanding and met patients' needs.

The physiotherapy team went to great lengths to develop and evolve their service based on the latest evidence of best practice. The team was developing an 'intensity of practice' programme to reduce falls and improve rehabilitation outcomes by utilising key factors from a range of international research. The programme focused on increasing each patient's amount of physical exercise through more physiotherapy sessions and access to activities with other staff. The team use an established framework to structure the programme and target improvements to specific patient outcomes.

Therapies teams held regular meetings to review new equipment and technology that had potential to improve patient care and outcomes. They reviewed research outcomes and evidence papers to identify how they could use the equipment in this specific service. This was part of the team's strategy to ensure all care and treatment decisions were evidence based.

Staff used a 'high observation daily intentional rounding system' to document observations and monitoring of patients. This system enabled staff to document observations at times specific to the patient's needs, such as increasing frequency in line with clinical condition.

A speech and language therapist presented their work at international conferences as part of good practice in rehabilitation care learning and knowledge sharing.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Dieticians reviewed patients with complex needs weekly, including those with unplanned weight changes. Speech and language therapists worked with the catering team to plan modified diets such as fortified meals or foods with specific textures. They provided care plan support to ensure patients received the most appropriate level of nutrition and hydration to meet their needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. They referred patients to a dietician or nutritionist where patients had more complex needs.

Staff coordinated mealtimes as an important structured part of the daily routine. Mealtimes were protected and visitors were not allowed to visit during these times, unless in exceptional circumstances.

The service provided adapted equipment to support patients to eat independently or with minimal support.

Requires Improvement

Community health inpatient services

Pain relief

Staff did not consistently document pain assessments or pain relief. While staff said they assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way, this was not confirmed by records. Staff supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff said they used a recognised tool to assess pain but did not always document the assessment or the results. They gave pain relief in line with individual needs and best practice.

The hospital director recognised this as an area for improvement and had introduced a range of measures in response. This included a new physical health policy, improved staff training, and the implemented of more reliable pain assessment tool. Part of the improvements reflected learning from an incident, which was evidence of good practice.

Patients received pain relief soon after requesting it and nurses worked with psychologists to ensure pain relief was appropriate and not symptomatic of other needs.

Staff used visual communication tools to help patients communicate when they were in pain and were trained to interpret such messages.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Staff used the functional independence measure (FIM) and the functional assessment measure (FAM) to assess patient rehabilitation outcomes during their admission. FIM and FAM are internationally-used tools to assess progress in motor gains and cognitive gains during a period of admission. The two systems are used together and included a 30-point scale for assessing progress. The most recent data available related to September 2022, which indicated outcomes better than other providers for level one patients, and comparable or worse results for level two patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The therapy team audited their therapy session times to identify the proportion spent on rehabilitation activities and to consider any possible efficiencies in ways of working. The most recent audit took place in early 2022 and found overall good standards of practice, with 73% of time spent active in session or engaging in interventions with patients. Of the inactive time, 4% was due to a patient declining a session and 2% due to the patient's medical condition. The team used the results to review how they planned therapy time, which resulted in a dedicated member of staff working each morning to prepare higher dependency patients for their session.

The audit cycle formed part of the clinical governance framework and included audits of pain relief, pressure ulcer care, and staff response to medical emergencies. The hospital director tracked the audits on a three monthly basis and used the service improvement plan to identify areas for change or improvement.

Requires Improvement

Community health inpatient services

The service was accredited by the Headway Approved Provider scheme and achieved an outstanding rating during their most recent inspection. This accreditation scheme recognised standards of care in residential care settings for patients with brain injuries. The service had affiliations with the Independent Neurorehabilitation Providers Alliance, the South West Acquired Brain Injury Group and the Restraint Reduction Network. This enabled the team to keep up to date with national learning and best practice.

Staff recorded a wide range of patient's holistic achievements and progress in their rehabilitation. For example, staff documented their success with supporting a patient to complete their own meal plan and food shopping. In another example staff supported a patient to access the community using good road safety practices. These were examples of significant achievements that reflected good standards of care.

Therapy staff provided rehabilitation five days a week from Monday to Friday. This was in line with international research and established patient outcome measures that found patients recovered more quickly and with better outcomes if therapy was not delivered every day and they had a break to recover between sessions.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers made sure staff received any specialist training for their role. They provided staff with service development time and encouraged them to lead on their own projects, which they presented to the rest of the team as examples of shared practice and learning.

Substantive staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. They were able to develop with specialist training in areas of interest to them, such as with training in falls management, diabetes, and acute head injuries. Heads of department supported their teams with continuing professional development plans.

Rehabilitation assistants supported colleagues to develop competencies. They were preparing exercise champion competencies to formalise the role and had developed splint workshops to help staff practice their skills. This was part of a strategy to upskill nurses and therapists in some aspects of the other teams' respective roles.

Managers gave all new staff a full induction tailored to their role before they started work. Staff spoke variably about the induction process and said a number of aspects could be improved. The senior team were reviewing induction practices as part of an overall plan to improve staffing. While agency nurses completed an induction before they provided care, this did not result in standards or consistency of competence equivalent to the substantive team.

Managers supported staff to develop through yearly, constructive appraisals of their work. They supplemented this with eight-weekly one-to-one supervision sessions. At the time of our inspection 95% of staff had completed an appraisal in the previous 12 months and 81% were up to date with their supervisions.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Requires Improvement

Community health inpatient services

The care model was multidisciplinary by nature and delivered by rehabilitation doctors, rehabilitation nurses, psychologists, physiotherapists, occupational therapists, speech and language therapists, discharge coordinators and activity co-ordinators. A dedicated team of administrators, housekeepers and catering staff provided services and support.

Staff held regular and effective structured multidisciplinary meetings to discuss patients and improve their care. This included scheduled meetings and ad-hoc meetings staff arranged based on changing needs or to review progress. Other clinical meetings and processes were multidisciplinary by design. For example, multidisciplinary team members joined daily flow meetings, huddles and handovers, the weekly behaviour meeting and monthly relative forums.

Staff referred patients for mental health assessments when they showed signs of mental ill health and depression. Neuropsychologists and clinical fellows worked together to identify the best course of action for patients with complex mental health needs.

A multidisciplinary behaviour specialist team worked together to plan highly individualised care for each patient. They used behaviour meetings thoroughly review needs and we saw the team had a clear focus on finding innovative solutions to challenging situations.

The lead physiotherapist and deputy matron had implemented a new listening and ideas workshop that brought together staff from across departments and roles. It included a strategy to improve multidisciplinary working by providing a forum for staff in different roles to share their successes, challenges, and ideas. The first workshop included staff from six different teams and represented good standards of practice in seeking improvements.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff facilitated a health promotion ethos in all aspects of care, which reflected the rehabilitative nature of the service. The team was proactive in sourcing materials from other services with whom they worked to adapt for patient needs. This reflected best practice and meant staff adapted evidence-based health promotion materials for local need. For example, a physiotherapist had created a health promotion resource from the Royal College of Physicians' guidance on prolonged disorders of consciousness to support patients who experienced sudden onset brain injury.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, alcohol was prohibited on site and staff worked individually with patients to assess risk of alcohol consumption, such as during community or family visits.

Activity coordinators took a lead role in daily stimulation and exercises outside of formal therapy sessions. They worked with patients to improve brain health and physical health by developing bespoke plans for each patient. Staff adopted 'champion' roles in the service to help enhance patient outcomes, such as exercise champions who worked with the wider team and patients to promote good outcomes from consistent exercise.

A member of staff had completed a National Centre for Smoking Cessation and Training programme and worked with patients to support smoking reduction. They provided patients with nicotine replacement therapy as part of health and care planning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Requires Improvement

Community health inpatient services

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Psychologists and senior nurses supported the team to adhere to this and support patients through providing choices and supporting them in decision-making.

Staff assessed patients' capacity on admission and worked with referring professionals to understand the scope of any problems with capacity. They reassessed patients in line with their individual needs.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff worked with patients to establish how much information to share with their next of kin, who could be involved in care planning and review meetings on request by the patient. Where patients did not have the ability to consent, staff ensured they confirmed the patient's power of attorney status before sharing information or gaining consent for treatment.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff implemented DoLS in line with approved documentation. A senior member of staff audited compliance with DoLS and the MCA quarterly.

The senior team monitored the use of DoLS and made sure staff knew how to complete them. At the time of our inspection 32 patients were being care for under a DoLS authorisation. Staff knew how to deliver the least restrictive care in line with national legislation and National Institute for Health and Care Excellence (NICE) guidance.

We reviewed DoLS authorisations and found staff made person-centred referrals and clearly documented considerations of safety. We spent time with staff who accompanied patients into the community whilst being cared for under a DoLS authorisation. They had a detailed understanding of DoLS, its impact, and what it meant for how they delivered care.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Staff could describe and knew how to access policies and get accurate advice on Mental Capacity Act. We were assured the provider's policies, training, and supported enabled staff to deliver effective care in line with guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (MHA) and the Mental Capacity Act 2005 and they knew who to contact for advice.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Requires Improvement

Community health inpatient services

Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. During most of our inspection we saw this applied to people's visitors and relatives.

Patients said staff treated them well and with kindness. One patient told us, "Staff are fantastic, they are always there to help you". Patients told us their mood had improved since admission. One patient said, "I'm just much happier after a week here, I'm very pleased with my progress." A patient's relative said, "The nursing care is excellent," and another said, "I think it's fabulous here and the nurses are wonderful".

Staff followed policy to keep patient care and treatment confidential. We saw staff were discreet when having private conversations and ensured professional discussions took place in private areas.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Most staff used their experiences and skills to support compassionate care. We observed a rehabilitation assistant who had experience of personal training enthusiastically support a patient who wanted to improve their fitness. They said, "We'll go to the gym and you'll be ripped in no time! Get yourself strong and out of here!" The patient was delighted with this interaction and we saw the motivational impact it had.

On the weekdays of our inspection we found a very positive, enthusiastic energy throughout the service. Staff were attentive, motivated, and demonstrated that patient-centred care was a priority. We observed natural, friendly conversations and activities between staff and patients. However, during our weekend inspection we found a different atmosphere and care environment. While some staff were friendly and caring, others were distracted by personal mobile phones and disinterested in engaging with patients. We observed staff sitting in silence with patients on a number of occasions.

During our weekend inspection, we saw some examples of unfriendly, unwelcoming care towards patient's visitors. While substantive staff dealt with a medical emergency, agency staff were unable to give visitors access to the buildings and made no attempt to find a solution. In four instances agency staff were dismissive and unhelpful when asked by relatives or visitors for assistance. We observed two other instances of substantive staff dismissing requests for assistance in an unfriendly manner. While this reflected a different standard of service and care from the team's usual high standards, we were concerned there were no systems in place to correct it out of hours. After our inspection we raised this with the hospital director who provided evidence of immediate action to improve, including reviews of practice, standards, and training.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Requires Improvement

Community health inpatient services

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service operated structured visiting hours and made exceptions for patients in distress or where increased visits would support better outcomes.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. An independent mental health advocate (IMCA) visited the service weekly and offered patients private, one-to-one discussions to talk about their needs and work together to find solutions.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. They understood the profound nature of changes to people's lives and were demonstrably focused on improving patient's outcomes.

Staff demonstrated a clear understanding of the importance and impact of emotional wellbeing on outcomes. They recognised this as equally important as medical and physical care and worked with the wider team to ensure care reflected individual emotional needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. They provided emotional care and support and time to listen. We observed very high standards of interaction between a physiotherapist and a patient. The physiotherapist was encouraging and used positive reinforcement for an activity that reflected their clear understanding of the patient's personal mood and needs.

Patients said staff helped them with the risks of social isolation when they were first admitted. Three patients told us they had made good friends in the service as a result, which helped them feel happier and more content.

Understanding and involvement of patients and those close to them

Staff mostly supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients said they understood their goals and staff encouraged them in their achievements. One patient told us they could now walk without a walking aid, which was impossible when they first arrived.

Staff mostly talked with patients, families and carers in a way they could understand, using communication aids where necessary. They provided signposting and printed information for families to help them understand the nature of brain injury and how rehabilitation worked to improve health outcomes and patients' lives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The head of therapy and head of nursing facilitated a family forum in which family members could discuss care and treatment and staff helped improve their understanding and knowledge of brain injuries and the therapeutic treatment.

Staff supported patients to make decisions about their care. The multidisciplinary team used patient review meetings to discuss patient concerns and agree resolutions. Consultants met regularly with patients to discuss their needs and match care and treatment plans. They offered patients the choice to have their next of kin present during clinical reviews and made sure everyone fully understood the care being delivered.

Requires Improvement

Community health inpatient services

Patients and relatives gave positive feedback about the service. They said they appreciated staff efforts to be inclusive during activities and therapy and noted this resulted in better experiences and care. For example, an activities coordinator worked with one patient who did not enjoy social activities. They built a rapport, got to know them, and introduced one-to-one activities that met the same goals as social sessions but on an individual basis.

Staff responded positively to a relative's concerns raised during a forum and they worked together to address the key issues. Relatives told us they were pleased with staff attitude and responsiveness when listening to them.

Staff discussed expectations of rehabilitation and progress on admission with patients, such as the need to get out of bed and dressed as part of a routine for therapy activities. The team were updating the welcome booklet to reflect such expectations more clearly.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The senior team planned and organised services, so they met the changing needs of the patients. The therapy team and therapy assistants based exercise therapy care plans on individual need and long-term treatment planning. This meant each patient received an individualised care plan that reflected specific needs and goals. Staff incorporated personal preferences into such care, such as where patients enjoyed sports, the gym, or the hydrotherapy pool.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. Overnight and at weekends they had access to a 'hospital at night' system with a local NHS trust.

Activities coordinators planned a range of recreation sessions six days per week. They included board games, quiz nights and movie nights as well as baking sessions. Coordinators undertook training to be able to safely offer relaxation sessions such as massages, manicures, and aromatherapy. Staff celebrated holidays and festivals in line with patient beliefs and arranged fun seasonal sessions.

The head of therapy and head of nursing were responsive to people's feedback in family forums. For example, they were working with the hospital director to recruit a music therapist after relatives requested this type of therapy. The team was sourcing a new brand of air mattress after relatives noted the current type in use was noisy and disturbed sleep.

Therapists and discharge/community care coordinators were trained as keyworkers and each patient was assigned a named keyworker on admission. They acted as single point of contact for the patient during their admission and worked with them to ensure all aspects of care were tailored to their needs.

Requires Improvement

Community health inpatient services

The rehabilitation process was demonstrably patient-centred, and the team worked with patients to establish a personal timetable that included activities and therapy sessions. Staff used patients' own interests and preferences when preparing these as a strategy to promote the best chances of success. The team used monthly goal-setting meetings to help identify progress and areas for adjustment. As schedules were individualised, patients received different levels of input from the therapy teams. This reflected best practice and meant patients were involved in their own rehabilitation and recovery.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health needs received the necessary care to meet all their needs. The multidisciplinary team used a behaviour meeting to thoroughly review each individual's known and emerging needs as well as to coordinate care findings from across the teams. We observed staff used in-depth knowledge of patients to plan and coordinate care, such as recognising the causes of a patient's response to outdoor activities and working to make these sessions more useful and enjoyable. They worked together to adjust care plans as an exploratory approach to meeting patient's needs, such as by changing medicine administration times and therapy session times to reflect patient's most awake hours.

Staff were proactive in securing specialist care for patients when their needs changed. The team worked closely with colleagues at a local NHS hospital and secured short-notice appointments, such as for diagnostic imaging, when patients' conditions unexpectedly changed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff supported patients unable to communicate verbally by using visual tools such as picture books. Patients carried beck chains with small picture cards that enabled them to communicate with staff whilst mobile around the unit. Staff provided some patients with gesture booklets, which helped them to communicate their level of comfort and wishes.

Staff could source information leaflets available in other languages as well as translators and British Sign Language interpreters. They arranged such services in advance during the referral process and could source telephone translation support for patients admitted at short notice.

Staff across all departments spoke of frustration at not always being able to meet individual needs due to a combination of staffing pressures and very high levels of patient acuity. Despite these pressures, every member of staff gave us examples of how they had made a difference in a patient's life and improved their experience and care. For example, one member of staff sat with a patient each morning and had breakfast together, which was the first time the patient had agreed to this meal since admission.

Patients joined interview panels for new staff. This was a process designed to ensure new recruits could meet patient's needs by considering their skills and experiences directly with current patient's experiences.

Staff met monthly to review restrictive practice, including routine restrictions such as locked gates and doors, restricted Wi-Fi, and modified diets. The multidisciplinary team used behaviour meetings to review incidents that involved restraint. Staff worked together to identify triggers to patient's behaviour that required restraint and implemented care strategies to remove the need for restraint as soon as possible.

The service sourced holistic support for patients from external organisations. This included a pet therapy service, a weekly legal clinic, and weekly visits from an independent mental health advocate (IMCA).

Staff supported patients to access the community and make trips with friends and family if this was safe. Therapists accompanied patients for walks and trips to the local community using appropriate risk assessments.

The service had recruited a behaviour specialist. The aim was for them to help improve consistency in care delivery with patients who needed continual supervision.

Access and flow

Staff worked to minimise waiting times. Patients received the right care in a timely way.

Managers monitored waiting times from referral to admission. In September 2022 the average wait time was 31 days for level one patients and 11 days for level two patients. This was better than other providers, who averaged 39 days for level one patients and 14 days for level two patients.

Managers and staff worked to make sure patients did not stay longer than they needed to. Length of stay varied from a few weeks up to six months and depended on patients' level of need. Rehabilitation was one part of a longer care pathway and patients were typically discharged to community rehabilitation services or other specialist external services after their stay. The service monitored length of stay monthly and benchmarked this against comparable providers. In September 2022 the average length of stay for level one patients was 133 nights, compared with 106 nights for other providers. In the same period for level two patients, the average length of stay was 77 nights, compared with 62 nights in other providers. This reflected the more intensive level of therapy provided to patients and staff efforts to ensure they achieved specific goals before discharge.

Managers and staff started planning each patient's discharge as early as possible after admission. They reviewed discharge needs and aims during admission assessments and reviewed progress at daily meetings and in care reviews. Patients often stayed in the service longer than was clinically necessary due to challenges in securing appropriate onward package of care placements. Discharge coordinators worked across specialties to collate clinical information and prepare reports for package of care referrals.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Information on the complaints process was available in the welcome pack, in each patient's private room, in the lobby of each building, and on the service website. Staff encouraged patients to discuss any concerns or issues with the ward manager.

Requires Improvement

Community health inpatient services

Staff understood the policy on complaints and knew how to handle them. Ward managers resolved concerns and informal complaints themselves and then briefed the senior team. The service used a structured process for formal complaints, which included a peer review and investigation process to ensure fairness. We saw this process worked well in practice and enabled staff to learn from minor issues and complaints.

A member of staff at band seven or above investigated complaints and identified themes. The most frequent complaint themes were around care and treatment, communication, and attitude and behaviour of staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. In all the examples we looked at, staff response to complaints was compassionate and understanding. Staff investigating complaints acted in accordance with the Duty of Candour, apologised, and shared learning with patients and those involved in their care, such as family members.

Managers shared feedback from complaints with staff and learning was used to improve the service. They produced a newsletter distributed to all staff that presented lessons learned from complaint investigations.

Staff could give examples of how they used patient feedback to improve daily practice. For example, the physiotherapy team introduced a more dynamic model of communicating exercise timetables after a family noted dissatisfaction with the hydrotherapy pool closure.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The hospital director, who was the registered manager, was responsible for the service, with support from the head of therapy and the matron. A matron, two deputy matrons, and four ward managers made up the senior nursing team. They used governance systems and the service improvement plan to maintain oversight of priorities and challenges in the service. Heads of department led staff at team level, such as the lead occupational therapist.

The medical director led the psychologists and clinical fellows and coordinated treatment with the wider multidisciplinary team to ensure care met individual needs. They maintained oversight of all aspects of care and holistic service provision and ensured junior medical staff received support. The medical director was proactive in supporting medical staff to develop practice based on research findings and international developments in the field.

Team leaders and other senior staff were proactive in facilitating opportunities for staff to meet and develop effective relationships. The lead physiotherapist, ward manager, and senior nurses chaired and supported listening and ideas workshops that empowered staff to identify opportunities for improved practices.

The lead physiotherapist had developed a leadership training programme to support those new to leadership and management. The programme helped staff to develop leadership strategies and styles based on evidence of best practice and efficacy.

Staff spoke positively about ward managers and the heads of service and said they felt supported and empowered.

At provider level, the chief executive officer held overall responsibility for corporate oversight, with support from seven executive-level staff, including the chief medical officer, group director of quality, and group clinical director. The director of risk and governance provided oversight for the quality assurance framework and clinical governance processes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Staff understood the provider's vision and strategy and reflected this in their work. The senior team had worked with staff to adapt the provider's overarching vision to the service and adopted it as the local vision, recognising they shared the same goal of keeping patients safe. Staff were clear about how this applied to their individual work and patient care.

The senior team had developed strong links with other providers in the regional health system and used these relationships to support continuous improvement and shared problem-solving.

The chair of the listening and ideas workshops facilitated discussions on the provider's vision during group sessions as a local strategy to incorporate the provider's wider goals into local practice.

Culture

Staff felt respected, supported and valued. They were mostly focused on the needs of patients receiving care although there were notable differences between shifts. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff facilitated a culture of peer support and mutual development that recognised and rewarded achievements and enabled people to learn from mistakes. Substantive staff we spoke with were unwaveringly positive and enthusiastic about their experiences working in the service. The senior team called successes and achievements "wins", language staff said made them feel valued and proud of their work.

We found evidence of a supportive working culture centred on patients, amongst dedicated, motivated staff who provided peer support to each other. Staff recognised the emotional impact associated with providing care to patients with profound long-term needs and were working together to ensure they could access support. The lead therapist had developed an emotional support tool that enabled staff to identify when they would need more intensive support from each other or from the senior team. Staff monitored each patient's needs progressively during ward rounds and identified known complexities of care that acted as emotional triggers for staff, which enabled the senior team to identify when staff may require more support.

Staff said the new management team had resulted in improved welfare and that they felt listened to. The heads of service used an electronic system designed to mimic the incident reporting tool that staff could use to submit praise and compliments to colleagues for high levels of service. This reflected a refreshed approach to reward and recognition and was designed to improve morale.

During our weekday inspection we found good working practices between staff in different roles and levels of seniority. It was evident the leadership team had a clear presence and contributed effectively to the running of the service. However, during our weekend inspection there was limited evidence the work of the senior leadership team during the week had an impact. For example, we found a wholly different atmosphere with wide variances in the attitude and competence of staff and gaps in knowledge about initiatives from the senior team designed to improve care.

A new provider had taken over operation of the service earlier in 2022. Staff spoke negatively about this and said the changed ownership was stressful and made consistent work difficult to maintain. One member of staff said, “This was a huge unsettling transition and it was not well managed by [the new provider]. There was no sense of support for us centrally.” Another member of staff said they felt the provider was detached from the service and it was difficult to interpret what the organisation’s values were. Nurses we spoke with described frustration with the provider’s change to their own documentation systems and showed us how patient records and templates were often inconsistent because they could not find the correct material.

Governance

Governance processes were well established throughout the service although did not always assure the senior team of safe, quality standards of care. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The hospital director and their senior team used a quality assurance framework, standardised across the provider’s services, to manage governance. The framework provided continual oversight of the operation of the service, including compliance with national standards, audit performance, incidents, complaints, and a range of other measures. The director of risk and governance had a key role in provider-level governance and use local reports to benchmark the service regionally and nationally.

Governance systems were effective at identifying good practice and areas for improvement. A July 2022 quarterly audit of restrictive practice, including the use of rapid tranquilisation, found areas for urgent improvement relating to the documentation of risk and care in patient records. The hospital director implemented an improvement plan and worked with staff to ensure this was embedded in the service.

However, there were gaps in the effectiveness of governance systems. The incident reporting system worked well but the lack of effectiveness in the system used to investigate incidents meant opportunities for learning were limited. While the senior leadership team demonstrated how they acted on risks and implemented learning from incidents, understanding amongst staff was inconsistent. The senior team did not have assurance that all staff, regardless of role, contract, or pattern of work, had up to date knowledge of safety learning. After our inspection the hospital director provided evidence of work to improve the use of this system, including more effective implementation of learning from near miss reports.

The senior team had good oversight of regional health pressures and changes in demand. They noted a persistent increase in the level of physical and cognitive need of patients over the past five years and were working with the integrated care board and NHS England to identity opportunities for improved resources.

The provider and senior team used a weekly operational exceptions report as a key element of the governance process. The provider's executive team maintained oversight and individual directors supported areas for improvement.

Managers made sure staff attended team meetings or had access to notes when they could not attend. Most teams met monthly and we found a good standard of continuous communication between meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The provider's clinical governance system used a 'strength of evidence' scale to measure standards of practice and compliance with expected policies and guidance.

The provider had implemented a supportive engagement audit as a key element of the governance framework. The audit involved monthly cycles of observing staff engagement with patients and reviewing specific elements of this such as keeping patients within eyesight where they had supervision needs and the level of support in line with the individual's care plan. In the previous four months the service performed well, with engagement levels between 85% and 100% compliance with expected standards.

Monthly clinical governance audits included physical health, falls, and pressure ulcer management as a measure of clinical safety standards. The most recent audit related to August 2022 and found practice ranging from 60% to 99% compliance. Where the audit identified areas for improvement, the hospital director added the information to the service improvement plan (SIP).

The hospital director maintained the SIP in line with the clinical governance cycle. It enabled them to track improvements based on the level of urgency.

The quality assurance framework included a monthly audit of incidents to check on the management of risks and progress of learning and actions. The audit identified good practice and areas for improvement, such as where there was good identification of learning, but evidence of implemented changes needed more attention.

The senior team used a risk register to monitor and track active risks to the service, which were often identified by staff and patient feedback or incident reports. Current risks included Legionella outbreaks and site security following an incident in which a patient absconded. The senior team was working with staff to reduce these risks, such as through increased water testing and new risk assessments for patients at risk of absconding.

The hospital director and senior team were demonstrably aware of the pressures on the service from high use of agency staff at weekends. They had a recruitment plan in place to address this. However, there was a lack of assurance that risks associated with agency staffing were appropriately identified. During our inspection evidence from a number of different sources suggested higher levels of risk out of hours. One patient told us they did not feel safe around another

patient with behavioural needs when the shift was staffed by agency. They felt agency staff were untrained in supporting the patient's behaviour needs. A member of staff said, "Weekends feel on the edge of safe. We couldn't run the service without [agency nurses] but their training is really poor." One member of staff said a patient they knew well no longer asked agency staff for help after one individual did not know how to make a cup of tea.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The clinical governance audit included a review of local information and data management, such as the effective use of incident data to identify quality and safety of care. Staff had access to this information for their departments and the wider service and could access it to understand local challenges and needs.

All staff completed information governance and data protection training and the senior team audited standards of practice as part of governance processes.

The service monitored data on admissions and patient acuity in other services nationally to understand changing needs and demands.

A national data breach had occurred earlier in 2022, which affected the electronic patient records system. This affected all providers that used the system and was not unique to this service. Staff reviewed use of local digital systems in response to ensure they were secure and protected against such an incident.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Engagement with patients and their families was a clear priority for staff and was embedded in all aspects of care planning and delivery. The provider monitored the effectiveness of such processes through a quarterly patient and family member engagement audit.

The physiotherapy lead had established a listening and ideas workshop programme, which provided multidisciplinary staff with a structured forum to provide feedback and suggestions on the service and working conditions.

The senior team had built positive working relationships with NHS England and local commissioners to help support challenging discharge arrangements and reduce delays to discharge. This reflected a significant increase in the level of acuity of patients.

Staff facilitated weekly patient forums in which they encouraged patients to discuss their experiences of care in the service and provide open and honest feedback.

Staff prepared a monthly newsletter for patients and relatives, which helped them to keep track of the range of activities and initiatives taking place.

Requires Improvement

Community health inpatient services

Staff were proactive in engaging with communities outside of the service. A new housing estate had been built around the unit. They were working with a local school, with whom the service shared a fence, to prepare joint risk assessments for patients who attempted to abscond by climbing the fence. This work had resulted in a positive community relationship and staff from both sites were looking at plans to engage their respective communities in fun events.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The culture of exploratory learning, continuous improvement, and innovation was palpable across all teams. Staff were committed, passionate, and took pride in their work. They assessed improvements and project ideas using quality improvement frameworks and sought evidence to drive changes in policy and practice.

The physiotherapy team monitored international developments in rehabilitation care and explored emerging theories and practices to drive care at the leading edge of practice.

Staff continuously sought opportunities for improvement in practices and patient outcomes. The therapy team was preparing new joint activities with occupational therapists and new therapy assistant competencies to use as part of a buddy system. Both examples would improve patient care and drive good outcomes by exploring new ways of working.

The senior team had established a number of processes to support future staffing to better meet the demands on the service. This included supporting a three-month placement for an international rehabilitation student and working with a local university to provide opportunities for trainee physiotherapists.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance systems were in place but had not identified the risks presented by variable quality and competencies of temporary staffing out of hours. Quality assurance systems had not addressed inconsistencies in the completion of some risk assessments and clinical monitoring in patient records.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Completion rates of positive behaviour management training were low, which increased the risk of harm to patients and staff. • Standards of temporary staffing out of hours were inconsistent and did not always meet the safety needs of the service. • The completion of risk assessments and clinical monitoring in patient records was inconsistent and not always up to date. • While an incident management system was in place, it did not always result in effective categorisation of issues to reduce future risk.