WM QRS West Midlands Quality Review Service

NHS

Review of Care of Adults with Acquired Brain Injury

Herefordshire Health Economy

Visit Date: 5th December 2013 Report Date: February 2014

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INTRODUCTION

This report presents the findings of the review of the Care of Adults with Acquired Brain Injury which took place in Herefordshire on 5th December 2013. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for Care of Adults with Acquired Brain Injury (Draft 8, November 2013).

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services at Herefordshire Health Economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

HEREFORDSHIRE HEALTH ECONOMY

This report describes services provided or commissioned by the following organisations:

- Wye Valley NHS Trust
- NHS Herefordshire Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Herefordshire Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Herefordshire health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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CARE OF ADULTS WITH ACQUIRED BRAIN INJURY

HEALTH ECONOMY - PATHWAY

General Comments and Achievements

Reviewers were impressed that Herefordshire had a community team, the Herefordshire Acquired Brain Injury Team (HABIT), with specific expertise in the care of adults with acquired brain injury. Some aspects of the service were working very well and reviewers considered this provided a sound basis for improving and developing community services for all people with acquired brain injury in Herefordshire.

The patients and carers who met reviewers provided extremely valuable insight into the strengths of the local service, as well as about the areas which could be improved. Reviewers were very appreciative of the willingness of these patients and carers to share their experiences and asked that their thanks are conveyed to the patients and carers who they met.

The pathway of care for patients on the 'Return to Real Life' Programme was clear, well-structured and well-defined. About 10% of the service's patients were on this programme. The pathway for other patients was less clear.

Concerns

1 **Overall pathway of care**

The overall pathway of care for people with acquired brain injury was not clear and appeared to have gaps. Reviewers were particularly concerned about the early part of the rehabilitation pathway, including diagnosis and the process on discharge from hospital. Diagnosis was not part of the role of HABIT (Herefordshire Acquired Brain Injury Team) and it was not clear that arrangements for diagnosis of mild and moderate brain injury were robust, including within the County Hospital.

A member of HABIT visited the County Hospital each week in order to collect referrals and give advice on any patients about whom staff were concerned. The process of referral to HABIT from the County Hospital was not clearly defined and appeared to depend on which member of staff was on duty and whether they were aware of HABIT. Pathways of referral from other hospitals to which patients with brain injuries may be admitted were not clear.

People with stroke had 12 weeks of rehabilitation following discharge from hospital but other patients did not have a clear route to rehabilitation. HABIT was commissioned to provide rehabilitation one year post stroke. Carers who met the visiting team said that they 'felt abandoned' at the conclusion of the 12 week rehabilitation programme. Reviewers were told that neighbourhood and intermediate care teams may provide an interim service but this did not always happen.

Criteria for referral to HABIT were not clearly defined and patients and carers who met the visiting team said that access to the services was variable and depended on whether a patient's GP knew about it.

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SPECIALIST TEAM – HEREFORDSHIRE ACQUIRED BRAIN INJURY TEAM (HABIT)

WYE VALLEY NHS TRUST

The Herefordshire Acquired Brain Injury Team (HABIT was commissioned to see people from Herefordshire between the ages of 16 to 65 who had suffered an Acquired Brain Injury (ABI) arising from traumatic brain injury, infection or virus, metabolic disorder, post-concussion syndrome, tumour (not grade lV), stroke or aneurysms (12

months after event), or epilepsy with residual neurological deficit. The service provided long term support to help people and their families adjust to cognitive, emotional and physical changes after their acquired brain injury.

General Comments and Achievements

Patients and carers who met the visiting team were extremely positive about the care they received from HABIT staff. The service was provided by a small group of highly committed staff who were keen to develop and improve care for people with acquired brain injury. Reviewers were impressed that a social worker was part of the team. Other achievements included a Carers' Forum, fatigue sessions for patients who had completed their rehabilitation programme and the establishment of a 'Tai Chi' group. There was also a 'maintenance group' for those who had completed their rehabilitation programme.

Reviewers were also impressed by the service's involvement with the development of the Quality Standards and that a peer review visit was taking place so soon. The service had had little time to prepare for the visit and some aspects of compliance with the Quality Standards will improve through the team's ongoing quality improvement work.

Good Practice

1 The 'Return to Real Life' (RTRL) group rehabilitation programme was excellent for the 10% of HABIT's patients who received this programme. Potential participants were screened and, if suitable, between six and twelve people undertook a six month group rehabilitation programme. The programme was well-structured with very good documentation.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Mental health services for people with acquired brain injury**

Mental health input to services for people with brain injury was not routinely commissioned. Mental health support was provided on an informal 'goodwill' basis and for individual patients with more complex needs. This case by case approach was time-consuming and was not necessarily available at the most appropriate stage of patients' rehabilitation. Reviewers were particularly concerned that some patients who could be helped by input from mental health services were not receiving this care.

2 **Neuro-rehabilitation consultant**

The service had no input from a neuro-rehabilitation consultant. Reviewers considered that some sessional consultant input would help patient care in Herefordshire and would also improve liaison with other services and the overall patient pathway. This may also support improving the pathway from acute to community rehabilitation.

3 **Consistency of care for all patients**

Several aspects of care for the 90% of patients not on the 'Return to Real Life' programme were not yet in place, including multi-disciplinary assessments, care plans, review arrangements, care coordination, carers support and feedback arrangements. Uni-disciplinary goals and plans were evident but these were not coordinated and not formalised.

4 **Lead Clinician - Specific time for service management**

The HABIT lead clinician did not have any dedicated time in her job plan for the development of the service or for her managerial responsibilities. Specific time will be needed if the issues identified in this report are to be addressed.

5 **Staffing levels**

As well as the lack of input from a consultant in rehabilitation medicine and mental health services (see above), at the time of the review the service had no specialist nurse and only 0.5 w.t.e. physiotherapist, 1.5

w.t.e. occupational therapy (although some of this clinical time was spent on team leadership issues), 0.2 w.t.e. speech and language therapist, 0.3 w.t.e. counsellor, 0.8 w.t.e social worker and 0.75 w.t.e. therapy assistant. The neuro-psychologist post was vacant but had been advertised and an assistant psychologist was available and being supervised. Cover for staff absences was not available. The staffing needed for the service was not clear, partly because a significant number of patients were 'on review' rather than receiving active rehabilitation. Improving rehabilitation planning, review arrangements and monitoring of outcomes for all patients should enable the capacity of the service to be planned more formally.

Further Consideration

1 Arrangements for input from HABIT to the assessment of Herefordshire residents placed 'out of county' for whom return home was being considered were not robust. This appeared to happen on an ad hoc basis and it was difficult to see how assessments of out of county placements included appropriate consultant neuro-rehabilitation and mental health input under the arrangements in place at the time of the review.

2 Outcome data were not routinely collated and summarised, for example, in an annual report. This may be helpful, including for discussions with referring clinicians and commissioners.

3 Carers' involvement in goal setting and review did not appear to be happening routinely for patients not on RTRL. It may be helpful to talk with patients and carers about how and when they would like to be involved and how they can be empowered to contribute to goal-setting and care planning. Some patients and carers who met the visiting team commented that outcome measures, evaluations and funding forms were often sent to them at home. Carers identified this as an extra strain and commented that patients may be unrealistic about their abilities if completing forms at home. Some patients would have appreciated the opportunity to complete the forms with support while attending for rehabilitation.

4 A clear strategy for the future development of the service, agreed by commissioners, was not yet in place. Reviewers considered that this would be helpful for both HABIT and its commissioners so that developments could be phased and the service would not become overwhelmed by being expected to tackle all its issues while staffing levels are below those expected. As part of this work, it may be helpful to compare staffing levels with national recommendations for the size of population and number of patients cared for by the service. The scope to offer the 'Return to Real Life' programme to more Herefordshire residents and people from Powys could be considered as part of this work.

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COMMISSIONING

NHS HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

Concerns

1 Commissioning for the whole pathway of care for adults of all ages with acquired brain injury was not yet in place. A systematic approach to achieving the commissioning Quality Standards, alongside working with HABIT to develop a clear strategy for its future development, should ensure that appropriate issues are identified and addressed. An up to date service specification was in place for the 'Return to Real Life' programme but not for other aspects of the service.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Ben Ellis	Physiotherapist	Walsall Healthcare NHS Trust
Wendy Godwin	Commissioner	NHS Walsall CCG
Dr Alex Joseph	Consultant Physician, Neurological Rehabilitation	Wolverhampton & Walsall CNRT
Sarah Moss	Occupational Therapist Advanced Practitioner	Cambridge Community Services NHS Trust
Ben Parfitt	Strategic Clinical Network Manager, Mental Health, Dementia & Neurological Conditions	Birmingham, Solihull and the Black Country NHS England
Dr Kate Psaila	Clinical Psychologist	Cambridge Community Services NHS Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

The HABIT service were involved with the development of the Quality Standard but had very little time to prepare for the visit. Compliance with the Quality Standards will improve through the team's ongoing quality improvement work.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Care of Adults with Acquired Brain Injury			
Primary Care	1	0	0
Acute Hospitals: Wye Valley NHS Trust	2	0	0
Specialist Team: HABIT	36	13	36
Commissioning	3	0	0
Health Economy	**42**	**13**	**31**

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PRIMARY CARE

Ref	Standard	Met?	Reviewer Comment
FA-501	**Primary Care Guidelines** Guidelines on the primary care management of acquired brain injury should be in use, covering at least: a. Effects of brain injury, including physical, cognitive, emotional, behavioural, social, personal and practical problems b. Definitions of mild, moderate and severe brain injury c. Role of primary care in diagnosis, monitoring and management, d. Criteria for referral to a specialist brain injury service and information to be sent with each referral e. Acute exacerbations and acute complications, including arrangements for rapid access to a specialist opinion f. Chronic complications g. Available regional and local brain injury services, support networks, outreach services, self-help groups and community services.	N	Primary care guidelines were not available. Reviewers did not meet any representatives from primary care but were told that access into the service was variable and depended on whether a GP knew that it existed. Some patient information was available including a good leaflet on concussion. The available information was not always clear about the action that a GP was expected to take.

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ACUTE HOSPITALS

Ref	Standard	Met?	Reviewer Comment
FC-501	**Brain Injury Assessment and Management Guidelines** Guidelines on the assessment and management of patients with brain Injury should be in use, covering at least: a. Assessment of consciousness level (if there is any doubt whatsoever) by a team with specialist experience in profound brain injury b. Nutrition assessment and provision of nutrition via a nasogastric tube (if required) within 48 hours of admission c. Establishing a moving and handling programme within 48 hours of admission d. Mood and cognitive screening within seven days of admission e. Referral for assessment and rehabilitation planning by a specialist neuro-rehabilitation service or local community rehabilitation service, depending on the severity of the brain injury.	N	Reviewers saw no evidence of guidelines in use at the County Hospital, Hereford. Reviewers considered that patients with mild and moderate brain injury may not be being considered for referral to the service. Staff from HABIT went into the County Hospital weekly in order to pick up referrals. Referral to HABIT appeared to come from a relatively small number of staff and may therefore depend on who is on duty.

Ref	Standard	Met?	Reviewer Comment
FC-502	**Brain Injury Management Guidelines** Guidelines should be in use covering: a. Implementing agreed rehabilitation plan until the patient is medically fit for discharge b. Preventing secondary complications of brain injury (QS FJ-506)	N	Reviewers saw no evidence of guidelines on the management of patients with brain injury in the acute setting.

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SPECIALIST BRAIN INJURY REHABILITATION SERVICE:

HEREFORDSHIRE ACQUIRED BRAIN INJURY TEAM

Ref	Standard	Met?	Reviewer Comment
FJ102	**Service Information** Each service should offer patients and carers information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours (if applicable)	N	A service leaflet was available but did not cover opening hours or all aspects of the QS. A separate leaflet was available for the 'Return to Real Life' (RTRL) programme.

Ref	Standard	Met?	Reviewer Comment
FJ-103	**Condition-Specific Information and Discussion** Patients and carers should be offered discussion and written information about their condition, covering at least: a. Description of their condition and its Implications b. Talking and physical contact with the patient, including the importance of regular breaks c. Likely problems and how to manage them, including the fact that problems sometimes only become apparent weeks or months later d. Access to the regional Brain Injury Services Guide, which should include information about regional and local brain injury services, support networks, outreach services, self-help groups and community services e. DVLA regulations and driving advice f. Venous thrombo-embolism prevention g. Falls prevention h. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, staying warm (vulnerable adults), mental and emotional health and well-being. i. Information about legal assistance and possible compensation for personal injury and approved sources of information concerning legal assistance j. Sources of further advice and information	Y	Letters were sent to the patient and their GP which covered this information. Very good written information was available for people on RTRL.

Ref	Standard	Met?	Reviewer Comment
FJ-104	**Rehabilitation Plan** Each patient and, where appropriate, their carer should discuss and agree their Rehabilitation Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-care and self-monitoring c. Name of 'care coordinator' d. Leisure and recreation activities e. Vocational / educational rehabilitation f. Other therapeutic and rehabilitation interventions g. Early warning signs of problems, including acute exacerbations, and what to do if these occur h. Planned review date and how to access a review more quickly, if necessary Where applicable: i. Nutrition, including food and drink textures j. Moving and handling programme for each patient with limited mobility k. Graded programme to increase tolerance to sitting / standing l. Plan for the management of contractures m. Bowel and toileting regime n. Communication and language interventions o. Cognitive, emotional and behavioural management interventions and support p. Interventions and support for mental health problems q. 'Looking to the Future' Plan The Rehabilitation Plan should be communicated to all staff within the service and copied to the patient's GP and other relevant healthcare professionals involved with their care. In-patient services should copy the rehabilitation plan to relevant community rehabilitation services in the patient's local area.	Y	This QS was clearly met for patients on RTRL (10%) who had a rehabilitation plan. The 90% of patients with 1:1 sessions did not have a rehabilitation plan pulled together in the same way although individual elements were seen.

Ref	Standard	Met?	Reviewer Comment
FJ-105	**Review of Rehabilitation Plan** A formal review of the patient's Rehabilitation Plan should take place at least three monthly or, for patients in need of long term and on-going support, at least annually. This review should involve the patient, their carer, the 'care coordinator' and other appropriate members of the multi-disciplinary team and any other individuals or organisations. The outcome of the review should be communicated in writing to the patient, their carer, their GP, staff within the service and other relevant healthcare professionals involved with their care. In-patient services should copy the outcome of the rehabilitation review to relevant community rehabilitation services in the patient's local area.	Y	Patients on RTRL had a formal review of their rehabilitation plan. Others had components of this but it was not undertaken formally or documented in the same way.
FJ-106	**Contact for queries and advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear. Response times should be not more than the end of the next working day. All contacts for advice and the actual response time should be documented.	N	The service had a single phone number but evidence of response times was not available.
FJ-107	**Benefits Advice** Patients and carers should have easy access to benefits advice from an individual or organisation with specialist expertise in the needs of people with acquired brain injury.	Y	A social worker was part of the HABIT team and clients also had access to the Citizens Advice Bureau.
FJ-108	**Discharge Information** Prior to discharge from the service, patients and carers should be offered discussion and written information covering where applicable: a. Care and activities after discharge b. Re-entry to the service, if required c. Purchasing care through independent advisors d. 'Short breaks' available and how to access these e. Home care services, intermediate care and care homes f. Adaptions available for the home g. Opportunities to learn skills, techniques and routines necessary to maintain rehabilitation gains	Y	This QS was clearly met at the end of the RTRL programme. Arrangements for other patients were not clear. In practice, few patients were discharged from the service and the majority of patients were kept 'on review'.

Ref	Standard	Met?	Reviewer Comment
FJ-196	**General Support for Service Users and Carers** Patients and carers should have easy access to the following services. Information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. Independent advocacy services c. Complaints procedures d. Spiritual support e. *HealthWatch* or equivalent organisation	Y	This QS was met for RTRL. Other patients had individual support on an ad-hoc basis.
FJ-197	**Carers' Support** Carers should have discussion and written information about: a. What to do in an emergency b. How to access: i. An assessment of their own needs ii. Carer's breaks iii. Services which provide support for highly dependent people at home at short notice iv. Support for children in the family (if applicable) v. Counselling and cognitive and behavioural therapy	N	Good carers support was available for people on RTRL. Carer support for other patients was not as clear and comprehensive. It was not clear that other carers received written information. More written information for children in the family may also be helpful.
FJ-199	**Involving Users and Carers** The service should have: a. Mechanisms for receiving feedback from patients and carers about the care and treatment they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	N	A feedback programme was in place for RTRL but was not evident for other patients.
FJ-201	**Lead Healthcare Professional** A nominated lead clinician should have responsibility for ensuring implementation of the Quality Standards for the service. The lead clinician should undertake regular clinical work within the service, should undertake Continuing Professional Development of relevance to this role and should have session/s identified for this role within their job plan.	N	A lead clinician was in place but had no protected time for the role within her job plan.

Ref	Standard	Met?	Reviewer Comment
FJ-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences, and cover for absences, should be available for the: a. Number of patients usually cared for by the service b. Service's role in the patient pathway c. Therapeutic and rehabilitation interventions offered The following specialist staff should have competences in caring for people with acquired brain injury and time for their work in the service identified in their job plan: i. Consultant in rehabilitation medicine ii. Other medical staff iii. Specialist nurse/s iv. Physiotherapy v. Occupational therapy vi. Psychological therapy vii. Dietetics viii. Speech and language therapy ix. Social work x. Consultant psychiatrist and mental health nurse xi. Therapy assistant	N	See main report.
FJ-214	**Competences – All Healthcare Professionals and Support Workers** All healthcare professionals and support workers working in the Unit should have competences appropriate to their role in: a. Adult safeguarding b. Recognising and meeting the needs of vulnerable adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Safe and appropriate moving and handling of patients f. Resuscitation	Y	
FJ-218	**Service Competences and Training Plan** The competences expected for each role providing care for people with acquired brain injury should be identified and the training and development plan for achieving and maintaining these competences described.	N	The Knowledge and Skills Framework (KSF) was not specific to brain injury and there were no specific competences for the brain injury service.

Ref	Standard	Met?	Reviewer Comment
FJ-299	**Administrative and Clerical Support** Administrative, clerical and data collection support should be available.	Y	The service had 0.8 w.t.e. administrative support. It was not clear if this included support for data collection.
FJ-304	**Support Services** Timely access, including telephone advice and referral, to the following services should be available: a. Tissue viability specialists b. Epilepsy specialist nurse and consultant neurologist with particular interest in epilepsy c. Neurophysiology d. Continence advisors e. Chronic pain team f. Neurology g. Ophthalmology h. Employment and education services i. Pharmacy	N	Point 'b' was not met. Evidence for point 'f' was limited. There was no access to pharmacy (point 'l') and no epilepsy specialist nurse was available. It was noted that some access routes to services had recently changed.

Ref	Standard	Met?	Reviewer Comment
FJ-305	**Specialist Services for People with Acquired Brain Injury** Timely access to telephone advice and referral for assessment and /or therapeutic intervention to the following specialist services should be available, a. Multi-disciplinary tracheostomy team (including nurses, physiotherapists and speech and language therapists) b. Multi-disciplinary team with experience in the management of spasticity c. Neuropsychology and neuropsychiatry d. Neuro-endocrinology e. In-patient and day specialist acute brain injury rehabilitation providing physical, neurological and neuro-cognitive rehabilitation interventions f. In-patient mental health assessment g. Forensic mental health services, including for the care of sexual offenders h. Functional Electrical Stimulation i. Services for people with very complex disabilities including physical, cognitive and/or communicative deficits j. Specialist equipment including specialist wheelchair and seating systems k. Services providing electronic assistive technology or communication aids l. Services for people with significant and challenging behavioural problems m. Services for people who are minimally conscious or in persistent vegetative states As part of the care pathway, specialist services should provide training and guidance for local teams involved in the care of patients with acquired brain injury.	Y	Point 'a' was not applicable. All other aspects of the standard were met.

Ref	Standard	Met?	Reviewer Comment
FJ-401	**Facilities** All services should have: a. Appropriate facilities for the assessment and management of patients with cognitive, behavioural, physical, psychological, communication and functional difficulties b. In-patient facilities only: i. Single rooms with sufficient space for use of hoists and equipment ii. Bathrooms and toilets with sufficient space for use of hoists and equipment iii. Appropriate hoists and equipment iv. Quiet areas v. Areas for families and carers, including access to refreshments	Y	Most care other than RTRL was provided on a domiciliary basis. There was also appropriate space and equipment for neuropsychological assessment and intervention.
FJ-402	**Equipment** Timely access to equipment should be available, including at least: a. Resuscitation drugs and equipment, checked in accordance with local policy b. Pressure relieving mattresses and equipment c. Arrangements for calibration (if required), planned maintenance and emergency repair of all equipment used by the service d. A system for tracking, return and recycling of equipment (if appropriate) e. Store of appropriate equipment	N	No information about, or links to, equipment suppliers was available. Arrangements for advice for people if they had problems with equipment were not clear.
FJ-501	**Diagnosis Guidelines** Guidelines on the diagnosis of acquired brain injury should be in use.	N/A	The service did not diagnose brain injury and it was not clear where diagnosis was being undertaken in Herefordshire.

Ref	Standard	Met?	Reviewer Comment
FJ-502	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use, covering at least: a. A full review of the patient's needs for rehabilitation and support b. Nutrition assessment c. Provision of nutrition via a nasogastric tube d. Establishing a suitable moving and handling programme for each patient with limited mobility e. Assessment of mental capacity and Deprivation of Liberty Safeguards f. Discussion with the family or carers to establish their own needs and gain further insight into the needs of the patient within the home environment g. Feedback to the patient, their family or carers, their GP and to the referring clinician, summarising the results of the assessment and the recommendations made. In-patient services should complete nutrition assessment, provide of nutrition via a nasogastic tube (if required) and establish a moving and handling programme within 48 hours of admission.	Y	Brief initial assessments were undertaken. Individual discipline assessments took place thereafter but there were no multi-disciplinary assessments.
FJ-503	**Monitoring and Management Guidelines** Guidelines on routine management should be in use covering, at least, the management of: a. Spasticity b. Epileptic seizures c. Anxiety and depression d. Other mental health problems, including suicidal and self-harming behaviour and psychoses e. Post traumatic amnesia f. Confused or agitated behaviour g. Fatigue h. Cognition, emotional and behavioural impairment i. Communication problems j. Bladder and bowel problems k. Motor function and control difficulties l. Need for supportive seating and standing m. Aids and orthoses n. Sensory disturbance, including hearing or vision loss o. Pain p. Drug and alcohol problems Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305).	N	Guidelines were not clear and it was not clear which guidelines were applicable to the service.

Ref	Standard	Met?	Reviewer Comment
FJ-504	**Full Assessment (when conscious)** Guidelines should be use which ensure that all patients, once conscious, are assessed by the multi-disciplinary team for common neurological impairments including: a. Pain b. Motor impairments and movement c. Bulbar problems affecting speech and swallowing (in-patient services only) d. Sensory dysfunction including hearing or visual loss e. Cognitive problems, especially memory, concentration and orientation impairments f. Language problems g. Control over bowels and bladder h. Emotional, psychological and neuro-behavioural problems i. Mental health problems j. Functional ability, including Activities of Daily Living k. Assessment of participation, including social involvement l. Family circumstances m. Impact on carers and children Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305).	Y	The service were using the Mayo Portland Adaptability Inventory which covered all aspects of this QS. After initial assessment other assessments were done as required but these were not standardised and were not multi-disciplinary.
FJ-505	**Rehabilitation Planning** Guidelines on rehabilitation planning should be in use, covering at least: a. Patient and family involvement in agreeing the rehabilitation programme b. Rehabilitation interventions, their intensity, duration and goals (short- and long-term) c. Multi-disciplinary involvement in rehabilitation interventions d. Recording of interventions and outcomes e. Arrangements for review of rehabilitation programme f. Actions to be taken when goals are not met	N	This QS was met for RTRL patients but not for others.

Ref	Standard	Met?	Reviewer Comment
FJ-506	**Transition** Guidelines should be in use covering transition from the care of local paediatric or CAMHS services including: a. Involvement of the young person and, where appropriate, their carer in the decision about transfer b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	N	Arrangements for the care of young people with acquired brain injury transferring from children's services were not clear.
FJ-507	**Guidelines: Preventing secondary complications in severe brain injury** Guidelines on preventing secondary complications should be in use covering: a. Optimising respiratory function b. Tracheostomy management, including regular review, care and weaning c. Screening for and managing swallowing impairment, including instrumental diagnostic examination by video-fluoroscopy or Functional Electronic Stimulation d. 24 hour positioning and handling to avoid the development of contractures, pressure sores and aspiration into the lungs, and to allow satisfactory ventilation e. Regular inspection of skin areas at risk of pressure sores Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305).	N	Guidelines were not available.

Ref	Standard	Met?	Reviewer Comment
FJ-508	**Guidelines: Nutrition and hydration in severe brain injury** Guidelines on nutrition in severe brain injury should be in use, covering at least: a. Provision of nutrition via a nasogastric tube where patients are unable to maintain adequate nutrition orally b. At least weekly review of nutrition and hydration, including weighing the patient weekly c. Percutaneous endoscopic gastrostomy (PEG) feeding (or other appropriate stomal route) If the patient is unable to take adequate nutrition orally for more than two to three weeks after injury, unless contraindicated. d. Maintaining adequate nutrition and hydration during increased catabolism Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305).	N	Guidelines were not available.
FJ-509	**Transfer Guidelines** Guidelines on care during transfer should be in use covering at least: a. Transfer between units b. Transfer to and return from local acute hospitals	N	Guidelines were not available.
FJ-599	**Care of Vulnerable Adults** Guidelines for the care of vulnerable adults should be in use, in particular: a. Restraint and sedation (QS MC-504) b. Missing patients (QS MC-505) c. Mental Capacity Act and the Deprivation of Liberty Safeguards (QS MC-594) d. Safeguarding (QS MC-596) e. Information Sharing Agreement (QS MC-597) f. Palliative care (QS MC-598) g. End of life care (QS MC-599)	N	Guidelines were not seen and it was unclear if these were available.

Ref	Standard	Met?	Reviewer Comment
FJ-601	**Operational Policy** The unit/service should have any operational policy covering at least: a. Criteria for referral to the service, including any exclusions b. Arrangements for dealing with urgent referrals c. Arrangements for initial and full assessment (QS FJ-502 and FJ-504) d. Arrangements for agreement and review of the Rehabilitation Plan (QS FJ-505) e. Allocation of the 'care coordinator' f. Arrangements for mental health input into the care of patients (QS FJ-602) g. Weekly multi-disciplinary meetings to review patients' rehabilitation goals and progress towards these, Rehabilitation Plans and discharge plans h. Input to reviews and discharge planning for local people with acquired brain injury who are being cared for outside the local area (community services only) i. Specialist in-patient services only: Communicating with community services and commissioners in the patient's local area about: i. Admission to the service ii. Outcome of assessments, rehabilitation plans, review dates and reviews of rehabilitation plan iii. Invitation to attend all review meetings j. Regular meetings with families k. Criteria for discharge from the service l. Arrangements for discharge (QS FJ-603 and FJ-604) m. Details of local and specialist services to which patients are usually referred (QS FJ-304 and FJ-305) and how to contact them	N	An operational policy meeting the requirements of the Quality Standard was not yet in place and some aspects were not yet commissioned.

Ref	Standard	Met?	Reviewer Comment
FJ-602	**Mental Health Input** Arrangements for mental health input to the care of patients should be in place, including: a. Attendance at multi-disciplinary team meetings b. Input to the assessment and management of patients with acquired brain injury, including triage and referral to neuro-psychiatry c. Care of patients with pre-existing mental health problems d. Input to reviews of local people with acquired brain injury who are being cared for outside the local area e. Training and development of staff in the specialist brain injury rehabilitation service in the care of people with mental health problems f. Input to audit programmes	N	Some informal links were in place and mental health input was arranged on a case by case basis but normally only for patients with more complex needs. Formal arrangements for ongoing mental health service input to the care of patients were not yet in place.

Ref	Standard	Met?	Reviewer Comment
FJ-603	**Discharge Planning Protocol (In-patient services only)** A discharge planning protocol should be in use, covering at least: a. Identification of a lead member of the multi-disciplinary team who will coordinate the patient's discharge b. Risk assessment, including safety in the proposed environment and risk to others, particularly children. c. Assessment for common neurological problems d. Need for continuing active rehabilitation and how this will be met e. Awareness of the person and their carers of the current problems and how to manage them f. Preparation of the patient and family g. Assessment of the discharge destination environment and support available h. Provision of any equipment and adaptations required i. Training of carers or family in the use of equipment and in managing the patient to ensure patient safety in the home environment j. Graded discharge, usually with short stay or weekend visits at home k. Handover to community teams, primary care teams and social services before discharge l. A written care plan copied to the patient, carer, the patient's GP and any services involved in their care and covering: i. All aspects of QS FJ-108 ii. Current needs iii. Planned care and handover to community rehabilitation services iv. Medication v. Standardised outcome measures at the time of discharge vi. Planned follow up (if applicable) vii. Contact for queries viii. Sources of continued information, support and advice m. Standardised outcome measure assessment, as a baseline for follow up (QS FJ-701)	N/A	

Ref	Standard	Met?	Reviewer Comment
FJ-604	**Follow up and Evaluation of Longer-term Outcomes** Arrangements for follow up of each patient between 12 and 18 months after discharge, either by visit or phone, should be in place in order to assess: a. At least one standardised outcome measure b. Whether gains made during rehabilitation have been maintained c. Whether recommendations made at discharge were implemented, and whether there are other unmet needs	N	The service did not evaluate clients after discharge unless they were re-referred.
FJ-605	**Annual Review Meetings** Meetings should be held at least annually to review liaison and address any problems identified with: a. Mental health services b. Benefits advice service c. Local acute hospital/s to which patients may be admitted	N	Annual review meetings were not yet in place.
FJ-701	**Data Collection** There should be regular collection of data and monitoring of: a. Goal attainment for each patient on agreement of the Rehabilitation Plan and at least three monthly thereafter b. Outcomes for the individual patient on agreement of the Rehabilitation Plan and at least three monthly thereafter c. In-patient services only: Completion of nutrition assessment, provision of nutrition via a nasogastic tube (if required) and establishing a moving and handling programme within 48 hours of admission.	N	Some data were collected (point 'a') but data were not routinely collected on individual patient outcomes.
FJ-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based guidelines (QS FJ-500s) b. Goal attainment and outcomes from patients' rehabilitation programmes	N	A rolling programme of audit was not yet in place.
FJ-798	**Multi-disciplinary Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from: a. Positive feedback, complaints, outcomes, incidents and 'near misses' b. Published scientific research and guidance	N	A weekly team meeting was in place but it was not clear if all aspects of this QS were covered within the meeting in a systematic format.

Ref	Standard	Met?	Reviewer Comment
FJ-799	**Document Control** All policies, procedures and guidelines should comply with the document control procedures of the Trust or employing organisation.	Y	This QS was met for RTRL documentation. Little other documentation was available.

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COMMISSIONING

Ref	Standard	Met?	Reviewer Comment
FZ-601	**Commissioning of Services for Adults with Acquired Brain Injury** The following services for people with acquired brain injury should be commissioned: a. Local community rehabilitation service/s b. Mental health input to the care of people with acquired brain injury (QS FJ-602) c. Input by community rehabilitation service/s and mental health service/s to Input to reviews and discharge planning for local people with acquired brain injury who are being cared for outside the local area d. Access to specialist services for people with acquired brain injury (QS FJ-305) e. A range of living options including: i. Transitional accommodation for those with improving independence ii. Long-term supported living iii. Specialist long term residential care, including for people with challenging behaviour or neuro-behavioural problems Criteria for referral to and discharge from each service should be specified.	N	Point 'b' was not met as mental health input was only commissioned for patients with more complex needs. Point 'c' was not specifically commissioned and, input was only on an ad-hoc basis. Options relating to point 'e' were 'spot-purchased'. Point 'd' was met.
FZ-602	**Local Strategy and Coordination** The lead local commissioner should develop and review at least annually the local strategy for people with acquired brain injury with: a. Patient and carer representatives b. Local services commissioned for people with acquired brain injury (QS FZ-601 'a' and 'b') c. Relevant local voluntary organisations d. Responsible senior social services manager e. Local acute hospital representative f. Primary care representative	N	No strategy was in place and it was not clear that the commissioners had a clear understanding of the strategic fit of the service in relation to mental health and neurology services.

Ref	Standard	Met?	Reviewer Comment
FZ-701	**Quality Monitoring** The lead local commissioner should monitor aggregate data on goal attainment and outcomes from patients' rehabilitation programmes at least annually.	N	This QS was not met as the service did not produce aggregate data for monitoring purposes and no annual report was available.

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