WM QRS West Midlands Quality Review Service

NHS

Review of Care of Adults with Acquired Brain Injury

Hunters Moor Neuro-rehabilitation Centre

Visit Date: 10th March 2015 Report Date: June 2015

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INTRODUCTION

This report presents the findings of the review of services for Adults with Acquired Brain Injury that took place on 10th March 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Care of Adults with Acquired Brain Injury, Version 1, July 2014

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 in which 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 that reviewed the services at Hunters Moor Neuro-rehabilitation Centre. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

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

- Christchurch Neurological Rehabilitation Group
- NHS Solihull 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 Solihull 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 Hunters Moor Neuro-rehabilitation Centre 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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SERVICES FOR ADULTS WITH ACQUIRED BRAIN INJURY

SPECIALIST BRAIN INJURY REHABILITATION SERVICES

HUNTERS MOOR NEURO-REHABILITATION CENTRE

General Comments and Achievements

Hunters Moor Neuro-rehabilitation Centre became part of the Christchurch Neurological Rehabilitation Group two years before this review visit. The Centre functioned as three separate services:-

Olive Carter Unit: A challenging behaviour service able to support individuals who exhibited moderate to severe challenging behaviour. The therapy assessment process followed the same pattern as the other parts of the service but timescales were dependent on each client's level of challenging behaviour.

Janet Barnes Unit: A specialist nursing service offering rehabilitation for people with acquired and traumatic brain injuries and care for people with progressive neurological conditions. Residents could be both cognitively and physically impaired. The unit could care for clients with a limited degree of challenging behaviour if their physical needs required intensive nursing care. Support was available from neuro-psychiatrists and behavioural nurse specialists.

Community Reintegration Unit: This unit was designed to support individuals who had progressed from the Olive Carter or Janet Barnes Unit and were working towards greater independence, although the unit did take direct referrals from external agencies. Residents were able to participate in community activities supported by the interdisciplinary team.

The service had experienced a great deal of change over the previous two years, which was positively appreciated by staff working there. Staff were welcoming, appeared to enjoy working at Hunters Moor and were enthusiastic about caring for people with acquired brain injury. Team-working was good and all staff groups appeared actively to engage with the organisation's philosophy.

Christchurch Neurological Rehabilitation Group had a range of guidance available to staff including induction and corporate policies. Work on a framework of competence levels for all staff that could be implemented across all the Group's sites was being undertaken.

The environment was calm. Good facilities were available and these were well decorated and included appropriate private and communal spaces. Openness in dealings with clients and relatives was clearly evident. Families and carers were positively encouraged, if appropriate, to engage in the care of their relative.

Following referral, staff visited prospective clients and assessed their needs and suitability for admission to any of the rehabilitation areas. Examples were given where individuals were not deemed suitable, or their admission had been declined based on the needs of the existing residents, and these decisions were supported by the management of the service.

Medical cover was provided by a consultant in neuro-rehabilitation who attended one day and two evenings each week. A neuro-psychiatrist was also available two days per week at Hunters Moor. There was an agreement with PrimeCare to provided medical cover on Mondays, Wednesdays and Fridays plus 'out of hours' care. Reviewers were told that the GPs from PrimeCare attended regularly and were known to the staff and residents. At the time of the visit the service was changing its registration status from 'independent in-patient unit' to 'care home with nursing'. Managers considered that this would improve the primary care provision as it would ensure GP cover would be in place for all residents.

The service had good support from a Mental Capacity Act administrator who also oversaw Deprivation of Liberty Safeguards assessments.

Working relationships with Solihull Clinical Commissioning Group appeared to be working well, with an appropriate level of cooperation to ensure issues were addressed and action plans implemented.

Good Practice

1 A good range of information was available to individuals accessing the service. The information booklet was comprehensive and easy to read. It covered the philosophy of the service as well as giving information about each unit, and had pictures explaining the different staff groups.

2 Residents had a named Key Therapist and a named Nurse. This shared arrangement had improved communication and the coordination of care for residents, and ensured a good understanding of residents' goals and care plans. The arrangements also meant that cover for absences was available.

3 Staff providing psychological services were linked to other local centres. This arrangement also ensured a good level of supervision and training for Psychology Assistants.

4 Shortly before the review visit, Hunters Moor had introduced a 'friends and family test'. The resulting information was being analysed to see whether it correlated with other feedback from residents, families and carers. The NHS safety thermometer had also been adopted as a process of monitoring and measuring quality improvement.

5 Reviewers were impressed by the receptionists, who were welcoming and helpful and actively dealt with queries.

Immediate Risks: No immediate risks were identified.

Concerns

1 Two aspects of the governance of the service were of concern to reviewers:

   a. Guidelines for the therapeutic interventions delivered by the service were not yet in place. Reviewers were told that care plans were individually designed for each resident. It was not clear how the effectiveness and efficiency of this approach was ensured.

   b. Outcomes of therapeutic interventions were not yet being monitored. Data from initial assessments were available but not data on the outcomes achieved. Reviewers considered that data on therapeutic interventions delivered and the outcomes of these interventions were important in order to justify the level of care being provided.

2 Reviewers were told of delays in the rehabilitation pathway for residents who were ready to be discharged home; in particular, there were delays in the provision of social care and housing. More active and earlier engagement with relevant local authorities by Hunters Moor and by commissioners may be helpful in addressing this issue. Improvements in the overall governance of the service, including guidelines, care plans and outcomes monitoring, may help to facilitate movement along the care pathway and reduce delays.

Further Consideration

1 Arrangements for identifying and meeting the physical health care needs of all residents did not appear to be robust. At the time of the review visit residents remained registered with their own GPs. Sometimes GPs notified Hunters Moor of physical health checks required, which were then actioned, but this did not happen for all residents. It was not clear whether information on primary health care delivered by PrimeCare was communicated to residents' own GPs, or whether PrimeCare was expected to provide physical health checks for Hunters Moor residents. Hunters Moor sent a multi-disciplinary summary to the resident's GP following discharge from the service.

2 Risk assessments for deep vein thrombosis were not yet taking place, although there were plans for implementing these.

3 Reviewers suggested that the documentation of care planning, supplementary care plans and residents' case notes could be streamlined. These documents were all kept separately, and the main care plan folder was not always updated, including with the outcome of reviews. It was not clear that all relevant information was recorded in these notes, and there was potential for inconsistencies in the information recorded.

4 Reviewers suggested that several issues identified during the review visit should be reviewed, including appropriate audits, to ensure that all expected processes are being fully implemented. In particular:

a. An audit of Mental Capacity Act policy implementation may be helpful to ensure that the organisation's policy was being followed, especially in relation to the recording of 'best interests' for multi-disciplinary discussion of the care of residents who lack mental capacity.

b. Frequency of risk assessments: Risk assessments seen by reviewers had review dates but it was not clear that reviews were always undertaken as indicated.

c. Frequency of moving and handling assessments: Reviewers saw examples of review dates for these assessments that had passed, meaning that the assessment was not up to date.

d. An audit covering completion and recording of a full clinical assessment on admission. Documentation in the notes seen by reviewers were not always clear about whether this had taken place.

5 The level of pharmacy support for the service may benefit from review, to ensure, in particular, adequate oversight for residents on complex drug regimens.

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COMMISSIONING

All issues identified in the Hunters Moor Rehabilitation Centre section of this report will require commissioner support and monitoring to ensure they are addressed.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Marie Adams	Solihull Neuro and Adult Rehabilitation Team	Heart of England NHS Foundation Trust
Tina Dolan	Occupational Therapist	Birmingham Community Healthcare NHS Trust
Dr Zacchaeus Falope	Consultant in Rehabilitation Medicine	Birmingham Community Healthcare NHS Trust
Dr Chris Fear	Consultant Psychiatrist / Associate Medical Director	[2]gether NHS Foundation Trust
Wendy Godwin	Lead Commissioner Planned Care	NHS Walsall CCG
Dawn Hicklin	Therapy Lead – Stroke	Sandwell & West Birmingham Hospitals NHS Trust
Julie Ravenhall	Interim Associate Director Specialist Services and General Manager (Quality, Governance & Risk)	Birmingham Community Healthcare NHS Trust

WMQRS Team

Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE 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 varies 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.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Review of Services for Adults with Acquired Brain Injury			
Specialist Brain Injury Assessment and / or Rehabilitation Services	36	16	44
Commissioning	3	1	33
Total	39	17	44%

Pathway and Service Letters: The Standards are in the following sections:

FA-	Acquired Brain Injury Pathway	Primary Care
FJ-	Acquired Brain Injury Pathway	Specialist Brain Injury Assessment and / or Rehabilitation Services
FZ-	Acquired Brain Injury Pathway	Commissioning

Topic Sections: Each section covers the following topics:

-100	Information and Support for Patients and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

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Specialist Brain Injury Assessment and / or Rehabilitation Services

Ref	Standard	Met?	Comments
FJ-102	**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)	Y	A good booklet about the services was provided, which was comprehensive and easy to read. The booklet contained pictures of the units and information about the different professionals whom users and carers would meet during their stay.
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. Information about regional and local brain injury services, support networks, self-help groups and other services available to provide support 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 sources of information concerning legal assistance j. Sources of further advice and information, including national and local voluntary organisations	Y	Information was tailored to the needs of individual residents and carers. Staff provided condition-related information and directed residents and carers to other local and national information as required.

Ref	Standard	Met?	Comments
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.	Y	Rehabilitation plans were documented but sometimes kept separately from the other care plans. Patients who met with the visiting team were involved in their care planning. Care plans and goals were discussed with patients and carers within six days of arrival on the units. Patients had a named nurse and therapist.
FJ-105	**Review of Rehabilitation Plan** A formal review of the patient's Rehabilitation Plan should take place at least: • weekly (in-patient services) • three monthly (community services) • 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, including relevant community rehabilitation services in the patient's local area.	N	Supplementary care plans were updated but it was not clear from the main files that other care plans were always updated. Some records seen by the visiting team were not documented as having been reviewed as planned.

Ref	Standard	Met?	Comments
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 a sample of actual response time should be documented.	Y	
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	Access to benefits advice was via the key workers. Reviewers were told of delays in accessing social workers and advice on housing issues.
FJ-108	**Discharge Information** Prior to discharge from the service, patients and carers should be offered discussion and written information covering, where applicable: a. Expected date of discharge from the service b. Plan of care and activities after discharge c. Medication d. Re-entry to the service, if required e. 'Short breaks' available and how to access these f. Other services available to provide support and care, support networks and self-help groups g. Adaptions available for the home h. Opportunities to learn skills, techniques and routines necessary to maintain rehabilitation gains i. Who to contact with queries or for advice	Y	'd': Re-entry to the service was only offered if identified as part of the rehabilitation plan.
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	

Ref	Standard	Met?	Comments
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	Y	Family support meetings had been introduced shortly before the review visit.
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	Examples of changes made as a result of feedback and involvement of patients and carers were not evident. The User Group had been reinstated as it had not met since July 2014. 'Friends and Family' feedback had been introduced and results were being analysed.
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.	Y	

Ref	Standard	Met?	Comments
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. Physiotherapist v. Occupational therapist vi. Psychological therapist vii. Dietician viii. Social work ix. Consultant psychiatrist and mental health nurse x. Therapy assistant	Y	A comprehensive multi-disciplinary team was in place. Staffing models were in place to assess workload, and staff numbers were flexed depending on residents' needs. At the time of the visit reviewers were told that it was becoming more difficult to recruit to vacant registered nurse posts, and access to social workers was not always timely. Some rehabilitation assistants were trained to undertake drug administration. The service was planning to develop a rehabilitation assistant role to undertake some care duties. **Community Reintegration Unit**: Senior rehabilitation staff were on duty during the day and rehabilitation assistants overnight. **Janet Barnes Unit:** Staffing was based on clinical need and flexed accordingly. **Olive Carter Unit:** This was staffed with registered mental health nurses and registered nurses. Overnight there was one registered nurse and support staff. Staff said that annual appraisals and supervision were in place. Some accessed supervision from the unit in York.
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	N	Mandatory training was in place. Reviewers considered that further training was required around mental capacity and risk assessments: records did not always follow the organisational policy on documenting information about 'best interests' following MDT discussions, and risk assessments were not always reviewed as detailed in care plans.

Ref	Standard	Met?	Comments
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	A mandatory training plan was in place but not a competence framework for each role providing care. The Christchurch Group was in the process of developing a framework covering four levels of competences for all staff.
FJ-299	**Administrative and Clerical Support** Administrative, clerical and data collection support should be available.	Y	
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	Appropriate pharmaceutical support was not in place for medicines management, especially for residents on complex regimens such as clozapine. It was not clear that access to chronic pain and employment services was timely. The units had access to all other support services.

Ref	Standard	Met?	Comments
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 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 with prolonged disorders of consciousness 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	'a' was not applicable as the service did not accept patients with tracheostomies. Staff referred to local services for 'd', 'g', 'j', 'k' and 'l'.
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	Facilities were welcoming and spacious. Rooms had en-suite facilities. There was also access to 'quiet rooms', a multipurpose activity room and a kitchen area for families.

Ref	Standard	Met?	Comments
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	On the Olive Carter Unit resuscitation equipment was on order and staff would need to phone emergency services. On the Janet Barnes Unit resuscitation equipment was accessible, and all staff were trained in basic life support skills or first aid. Timely access to other equipment was in place.
FJ-501	**Diagnosis Guidelines** Guidelines on the diagnosis of acquired brain injury should be in use.	N/A	Patients were diagnosed with acquired brain injury before admission.
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 and provision of additional nutrition (if required) c. Establishing a suitable moving and handling programme for each patient with limited mobility d. Assessment of mental capacity and Deprivation of Liberty Safeguards e. 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 f. 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 nutrition via a nasogastric tube (if required) and establish a moving and handling programme within 48 hours of admission.	N	Guidelines were not in place covering initial assessments. An assessment checklist had just been implemented, which covered the initial 12 week pathway. In practice, care plans included all aspects of the QS.

Ref	Standard	Met?	Comments
FJ-503	**Monitoring and Management Guidelines** Guidelines on routine management should be in use covering, at least, the management of: a. Pain b. Spasticity c. Epileptic seizures d. Confused or agitated behaviour e. Fatigue f. Motor impairments and movement problems g. Bulbar problems affecting speech and swallowing (in-patient services only) h. Sensory dysfunction including hearing or visual loss i. Cognitive problems, especially mood, memory, concentration and orientation impairments j. Language and communication problems k. Bowel and bladder control problems l. Emotional, psychological and neuro-behavioural problems m. Mental health problems including anxiety, depression, suicidal and self-harming behaviour and psychoses n. Drug and alcohol problems o. Need for supportive seating and standing, aids and orthoses Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305).	N	Guidelines on routine management or indications for referral to other services were not in place. A number of assessment scales were used but not guidelines covering indications for use.

Ref	Standard	Met?	Comments
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 problems c. Bulbar problems affecting speech and swallowing (in-patient services only) d. Sensory dysfunction including hearing or visual loss e. Cognitive problems, especially mood, memory, concentration and orientation impairments f. Language and communication problems g. Control over bowels and bladder h. Emotional, psychological and neuro-behavioural problems i. Mental health problems including anxiety, depression, suicidal and self-harming behaviour and psychoses j. Functional ability, including Activities of Daily Living k. Assessment of participation, including social involvement l. Drug and alcohol problems m. Need for supportive seating and standing, aids and orthoses n. Family circumstances o. Impact on carers and children Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305).	N	Full assessment guidelines were not yet in use. Guidance on management of autonomic dysreflexia was in place. It appeared that assessments were undertaken but were not always documented fully.
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	Rehabilitation planning guidelines were not in place. In practice, goal-setting for individual patients was undertaken. There was limited evidence as to the recording of outcomes.

Ref	Standard	Met?	Comments
FJ-506	**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 preventing secondary complications in severe brain Injury were not yet in place.
FJ-507	**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 on nutrition in severe brain injury were not yet in place.
FJ-508	**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 on care during transfer were not yet in place. In practice, transfers did take place to acute hospitals, other care homes and residents' homes.

Ref	Standard	Met?	Comments
FJ-598	**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/A	The service did not care for people under the age of 18 years.
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 MM-598) g. End of life care (QS MM-599)	N	Neither guidelines on the use of sedation nor an Information Sharing Agreement were seen during the visit All other aspects of the QS were met.

Ref	Standard	Met?	Comments
FJ-601	**Operational Policy** The unit/service should have an 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	Written arrangements covering the criteria for referral to the service and arrangements for dealing with urgent referrals were not seen during the visit
FJ-602	**Mental Health Input** Arrangements for input to the care of patients by mental health clinicians with an interest in the care of patients with acquired brain injury 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	Y	

Ref	Standard	Met?	Comments
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 by a neurologist or a neurological rehabilitation specialist 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	No discharge planning protocol was in place. The new checklist included discharge but did not cover all areas expected by the QS. In practice, discharge plans were in place and discharge letters were comprehensive.
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	Arrangements for follow up and evaluation of longer-term outcomes were not yet in place.

Ref	Standard	Met?	Comments
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 with those identified in the QS were not yet in place. Regular meetings took place with local CCGs.
FJ-701	**Data Collection** There should be regular collection of data and monitoring of: a. Outcomes and goal attainment for the individual patient on agreement of the Rehabilitation Plan and at least three monthly thereafter b. In-patient services only: Completion of nutrition assessment, provision of nutrition via a nasogastric tube (if required) and establishing a moving and handling programme within 48 hours of admission.	N	See main report.
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	There was no rolling programme of audit covering 'a'.
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	Y	
FJ-799	**Document Control** All policies, procedures and guidelines should comply with the document control procedures of the Trust or employing organisation.	Y	The expected date for review was not always clear in the documentation provided.

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COMMISSIONING

Ref	Standard	Met?	Reviewers 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	The CCG commissioned from Hunters Moor on a 'spot purchase' basis. It was not clear that all the other expected services were commissioned.
FZ-602	**Local Strategy and Coordination** The lead local commissioner should develop and agree a 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	There was no Solihull strategy for the care of people with acquired brain injury.
FZ-701	**Quality Monitoring** The lead local commissioner should monitor aggregate data on goal attainment and outcomes from patients' rehabilitation programmes at least annually.	Y	Regular monthly meetings and a review of contractual arrangements had taken place. Hunters Moor had recently introduced the NHS Safety Thermometer.

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