Holy Cross Hospital

Quality Report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Overall summary

Holy Cross Hospital is operated by The Congregation of the Daughters of the Cross of Liège. The hospital has 40 inpatient beds. Facilities include: 40 single bedrooms with ensuite and overhead hoists, an inpatient physiotherapy gym and a separate Physiotherapy Centre for outpatients, a hydrotherapy pool with hoist to assist transfers, a sensory room, an activity room with a therapy kitchen, a sensory garden, and a woodland trail. At the time of inspection, the hospital was in the process of building an Education Centre.

The hospital provides support for patients with long-term conditions within the specialisms of: disorders of consciousness; postural and physical management; complex respiratory management; swallowing disorders and nutrition as well as providing assistive technology.

Physiotherapy services are provided to outpatients at the integrated physiotherapy centre, as well as the gym and hydrotherapy pool.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 28 and 29 March 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated this hospital as outstanding overall. We rated safe, effective and well led as good and responsiveness and caring as outstanding.

We found areas of outstanding practice:

- Patients were truly respected and valued as individuals an there was an emphasis on providing a care setting that patients could consider their home.There was an embedded culture of caring amongst all staff and we saw many examples of staff going the 'extra mile' to meet the needs of patients in ways that took account of their personal preferences. This included personal, cultural, social and religious needs.
- The hospital was at the forefront of care for people with long-term conditions. There was holistic approach to assessing, planning and delivering care and treatment to people who use services. The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. New evidence-based techniques and technologies were used to support the delivery of high quality care. Staff from the hospital had been invited to co-write Royal College of Physicians (RCP) guidelines regarding pain as well as to set up a patient group as part of a centre of excellence.
- When patients needed acute hospital care, there were arrangements for staff from Holy Cross Hospital to support patients in this environment, and also to support other professional staff in meeting the complex, individual needs of patients. Patients were welcomed when they returned.
- Services were tailored to meet the needs of individual patients whose needs and preferences are central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. There were opportunities for patients and those close to them to experience a range of environments. There was a woodland trail outside the hospital that was wheelchair friendly and provided views over the countryside, a sensory garden included a fishpond with waterfall, plants of varying colour and scent and a terrace. Patients also had access to a holiday cottage in Selsey.
- The hospital had established "Special Interest Groups" covering a range of clinical areas such as infection prevention and control to ensure best practice and guidance was reviewed, considered, disseminated and managed throughout the hospital.

We found other areas of good practice.

- People were protected from avoidable harm and abuse.
- There were systems to report and investigate incidents, to control the spread of infection, to manage medicines in line with legislation and current guidelines and to report and investigate suspected abuse.
- There were sufficient numbers of staff with the necessary qualifications, skills and experience to meet patient' complex needs.
- The leadership, governance and culture promoted the delivery of high quality person-centred care.

However, we also found the following issues that the service provider needs to improve. The hospital should:

- Expand information on duty of candour in the incident policy to indicate the practical application of candour as a point of reference for all staff.
- Have an auditable target in place for mandatory training completion.
- Follow through the chain of disposal external to the hospital for assurance at least annually.

Summary of findings

- Document a rolling schedule of planned preventative maintenance for equipment used to enable easy reference.
- Conduct additional resuscitation scenario training.
- Establish key performance indicators within the pathology service level agreement setting out reporting.
- Review its arrangements for advanced care planning.
- Review the use of syringe drivers to support patients on an end of life pathway and to provide medication where appropriate.
- Ensure all staff have an annual appraisal.
- Ensure all staff know how to access professional translation services.
- Devise a risk register that is prioritised and gives the management team assurance of safety across the organisation.

Professor Ted baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long term conditions	**Outstanding** ☆	Patients were protected from avoidable harm and abuse as there were systems to report and investigate safety incidents and learn from them. The hospital was visibly clean and well maintained and the risk of infection was controlled. Medicines were managed in line with current best practice and legislation. There were sufficient numbers of staff with the right skills to meet the needs of patients. The multi-disciplinary team worked effectively together. Care was delivered in line with national and international guidelines and practice was actively monitored and reviewed. There were arrangements to ensure patients' nutritional needs were met and any pain they experienced was managed. Where patients lacked capacity to consent, staff acted in accordance with the Mental Capacity Act 2005. We saw outstanding examples of care being organised and delivered with compassion. There was a focus on protecting rights and dignity of patients and those close to them and they were fully involved in decisions about care. Patients' individual needs and preferences were central to the planning and delivery of tailored services. Services were provided to support the holistic needs of patients. There were processes to receive, review and learn from feedback including complaints. The hospital had a clear set of values well understood and demonstrated by staff, who showed high levels of satisfaction with their work.

Summary of findings

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Outstanding ☆

Holy Cross Hospital

Services we looked at:
Long term conditions

Summary of this inspection

Background to Holy Cross Hospital

Holy Cross Hospital is one of the works of the charity, The Congregation of the Daughters of the Cross of Liege.

In 1917, the Congregation relocated a sanatorium from Ramsgate, Kent to Haslemere, Surrey. From the 1950's onward, the sanatorium was adapted to undertake a range of medical and surgical work, mostly through contractual arrangements with NHS bodies. By the 1980's the hospital focussed on the treatment and care of severely physically disabled adults. In 1992 a new hospital was built by the Congregation to provide specifically designed facilities to manage patients with complex neurological disorders.

The hospital has admitted patients requiring specialised respiratory support for tracheostomy and ventilator management since the 1980's and in 2009 they added a new building, the Physiotherapy Centre, to provide hydrotherapy for in and outpatients. At the time of inspection, the charity was funding a new Education Centre to support staff learning and development.

On the ground floor of the hospital there is a ward with 20 beds, all in single rooms with ensuite toilet facilities, there is also the reception, chapel, quiet room and offices and the hydrotherapy suite. On the first floor, there is another ward of 20 beds in single rooms with ensuite toilets, as well as an inpatient physiotherapy gym, living room, sensory technology room and an outpatient physiotherapy gym and consulting room.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Our inspection team

The team that inspected the service was comprised of a CQC Inspection Manager, Shaun Marten, two CQC inspectors and four specialist advisors with expertise in adult safeguarding, rehabilitation, hospital management and cardiac rehabilitation.The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection as part of our planned programme of comprehensive inspections.

How we carried out this inspection

During the inspection, we visited all areas of the hospital and observed the environment and care delivery. We spoke with 30 staff including; registered nurses, health care assistants, activity coordinators, volunteers, medical staff, therapists and senior managers. We spoke with six patients and four relatives. We also received 17 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 19 sets of patient records and looked at a wide range of documents relevant to the running of the service, including staff employment files, policies, meeting minutes and audit results.

Summary of this inspection

Information about Holy Cross Hospital

Holy Cross Hospital is operated by The Congregation of the Daughters of the Cross of Liège and is a private hospital in Haslemere, Surrey. The hospital primarily serves the communities in the South East of England. It also accepts patient referrals from outside this area. It is a very specialist service providing long-term support and rehabilitation services to people with extremely complex needs, including those with total dependence on mechanical ventilation.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

The most recent inspection of the hospital took place in February 2014, which found the hospital was meeting all standards of quality and safety it was inspected against.

The inspection in March 2017 was the first inspection under CQC's new methodology.

Activity

The hospital provided care to 40 patients at the time of inspection of whom eight were aged over 65. No children or young people were treated. The unit received 13 referrals for admission between October 2015 and September 2016. All patients were NHS funded through the Continuing Health Care scheme. NHS continuing healthcare is a free package of care for people who have significant ongoing healthcare needs arranged and funded by the NHS.

Most patients using the outpatient physiotherapy service were self-funding, and the service was restricted to adults.

Staffing

At the time of inspection the therapy team consisted of; 5.5 whole time equivalent (WTE) physiotherapists, 1.4 WTE occupational therapists (OT) and 0.2 WTE speech and language therapists (SALT).

There were 78 WTE nursing staff which comprised registered nurses (27.6) and health care assistants. Patients were under the care of a consultant in rehabilitation medicine, who was employed via a service level agreement (SLA). A local GP practice provided day-to-day medical care at all times via another SLA. Specialist therapists, such as a neuropsychologist, were also employed under similar agreements.

Track record on safety (October 2015 and September 2016);

- No reported never events
- No reported serious incidents
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA), hospital acquired Clostridium difficile (C.diff), or hospital acquired E-Coli
- No hospital acquired venous thrombo-embolism (VTE) were reported
- Four expected, and no unexpected deaths reported
- There were six complaints made to the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were clearly defined systems to report, investigate and learn from incidents and when things went wrong.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. They were supported by a programme of mandatory training in key safety areas.
- There were systems and processes for recognising and reporting potential abuse, for preventing and controlling infection and for managing medicines. These were well understood and implemented by staff.
- Risks to patients were well understood, and there were arrangements to assess and mitigate clinical risks for individual patients.
- Patient records reflected a multi-disciplinary approach to care with individual outcome goals that were regularly reviewed.

However

- There was limited information about duty of candour in the incident policy.
- There were no targets set for mandatory training completion.
- An audit of waste disposal external to the hospital was not completed.
- Resuscitation scenarios were not carried out separate to training scenarios.
- The pathology agreement did not include timeframes for when results will be returned to the hospital.

Are services effective?

Good

We rated effective as good because:

- The continuing development of staff skills, and competence and knowledge was recognised as being integral to ensuring high quality care. Staff were supported to acquire new skills and share best practice. This was shown in the development and use of Special Interest Groups (SIG).
- Teams were committed to working collaboratively both internally and externally.
- Consent practices and records were actively monitored and reviewed to improve how people are involved in making decisions about their care and treatment.

Summary of this inspection

- There were arrangements to ensure patients' pain was managed and controlled, and that their nutritional needs were met.

However:

- Appraisal rates were low and there was no target for staff completion.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Feedback from patients, those who are close to them and stakeholders was continually and overwhelmingly positive about the way staff treated people.
- There was a strong, person-centered culture amongst staff. Staff were highly motivated and inspired to offer care that was kind and promoted dignity. Relationships between people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders. Staff recognised and respected patients' needs and took personal, cultural, social and religious needs into account.
- Patients were active partners in their care. Staff empowered patients to have a voice and to realise their potential. Patient preferences and needs were reflected in how care was delivered. For example; the use of patient history and photographs when planning patient shopping trips and patient involvement in goal setting meetings.
- Patients' emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- Patients' individual needs and preferences were central to the planning and delivery of tailored services. Services were provided to support the holistic needs of patients. For example; the sensory room, activity room and the availability and frequency of visits to the holiday cottage in Selsey.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patient's needs. For example; the Physiotherapy Centre outpatient unit provided a service to the local community.
- There were innovative approaches to providing integrated person-centered pathways of care that involved other service providers.

Summary of this inspection

- There was a clear process to review complaints and how they were managed and responded to, and improvements were made as a result. The hospital received very few complaints and worked with patients and their families to resolve issues before they developed.

Are services well-led?

Good

We rated well-led as good because:

- There was clear understanding of values and they were well embedded and demonstrated in staff's daily work with both patients and their families. There was a common focus across all staff groups on providing high quality care.
- There was a robust governance framework and annual plan that detailed clear reporting lines and areas of responsibility with structured meetings. All members of the multi-disciplinary team (MDT) were seen to be actively engaged in the governance of the organisation.
- There were high levels of satisfaction across all staff groups. Staff were proud of the hospital, of the service provided, and spoke of a supportive and visible management team. There was a high level of staff engagement and staff were involved in planning major and minor developments in the service.
- There were systems for gathering feedback from patients and their families, gathering their views on delivery of care and all future developments.

However

- Departmental risk assessments need to be organised into a risk register that is prioritised and gives the management team assurance of safety across the organisation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long term conditions	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding

Notes

Outstanding ☆

Long term conditions

Safe	Good
Effective	Good
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Good

Are long term conditions safe?

Good

We rated safe as good.

Incidents and safety monitoring

- The hospital did not report any never events in the period October 2015 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were four expected deaths during the reporting period (October 2015 to September 2016) and no serious injuries. There were 87 incidents in the reporting period comprising 13 clinical incidents, 35 health and safety, 24 equipment, seven information governance, four security and four 'other' incidents. The report we saw categorised whether the incidents were of moderate or low harm. This suggested a good reporting culture at the hospital.
- The hospital monitored safety incidents such as pressure ulcers, falls, urinary tract infections (UTI) and hospital acquired venous thromboembolism (VTE) and had registered to submit data to the NHS safety thermometer - a point of care survey conducted one day a month. There were no falls or VTE's, one pressure ulcer, and 19 UTI's reported during October 2015 to September 2016.
- The hospital does not hold mortality or morbidity review meetings. Clinical Incidents were discussed at Clinical Governance and Health and Safety meetings. A summary review of the four deaths was reviewed during the inspection and showed us that these deaths were expected.
- The hospital policy stated that incidents should be reported through the hospital reporting system which was paper based. The director of nursing (DON) then entered this data onto an electronic system which showed actions taken and severity including whether any injury was sustained. All the staff we spoke with told us they were encouraged to report incidents.
- Staff described the process for reporting incidents and told us they received feedback, which was shared at report handover and by email. We also saw incidents were included on weekly briefing sheets, and these also showed learning. Staff in all departments told us following any incidents and investigations, the outcomes would be discussed at their meetings and minutes were shared with all staff. However, there was no assurance that all staff read the minutes of meetings.
- We saw root cause analysis (RCA) investigations were completed as part of the investigation of incidents. We saw reviewed three and saw they were completed appropriately on a standardised template. A completed patient related incidents action plan showed when incidents were discussed at the multidisciplinary team (MDT) meeting and whether the patient was informed of the outcome.
- Reviewing incidents was seen to be a standard agenda item at the quarterly clinical governance committee meeting. We were told and saw evidence of discussion

of incidents and planned actions. We saw a clinical governance report, including incidents and learning was circulated to the medical advisory committee (MAC) and was noted within their minutes.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'."
- The hospital had an incident policy that referenced duty of candour but did not detail how the decision to apply duty of candour should be made. This meant not all staff had a point of reference regarding the practical application of the duty of candour.
  - We asked staff about their understanding of duty of candour and they were able to give examples of how this could be applied. They spoke about being open and honest with patients and families.
  - There was mandatory duty of candour training for all staff that 79% had completed.

Mandatory Training

- We were told that training at the hospital was broadly classified into induction, mandatory and recommended training. Mandatory training was monitored and all staff were expected to complete it on an annual basis.
- We were shown the training plan for all staff which showed the mandatory training that should be completed by staff depending on their role. Training for clinical staff was seen to include basic life support, a respiratory workshop, mentorship, mental capacity act (MCA) and deprivation of liberty safeguards (DOLS), information management, conflict management, complaints, and compliments. There was also statutory training in fire and health and safety.
- The most recent training report showed percentage completion rates varied from 58% to 100%, but the target for compliance with mandatory training was unclear. A target for completion would help the management team manage performance in this area effectively.
- Much of the training was delivered face to face but the hospital had recently implemented an E-learning package for staff training and four topics were being offered to staff with a plan to increase this taking into account feedback from staff.
- A learning development administrator had been appointed recently and part of their role was to maintain the database of completed training and to encourage staff to complete their mandatory training.
- Staff told us that that they had good access to mandatory training and had protected time in order to complete it.

Safeguarding

- The hospital had an adult safeguarding policy. Hard copies of the policies and all information sheets were found on the ward area which meant staff had access to this information at all times. The policy included details of what action should be taken when suspecting a safeguarding concern. There were contact details of relevant authorities to contact and clear guidance on who to contact outside of office hours.
- A safeguarding flowchart gave clear guidance on action to be taken in the event of actual or suspected abuse. In addition, there was a protection of children policy that contained relevant detailed information of what action to take and how to report any concerns; it was noted that the hospital is currently not admitting children or young persons as patients.
- There were three designated safeguarding officer adults trained to level three in line with best practice
- The hospital training report showed that 100% of all staff had undergone basic safeguarding training and 97% clinical staff had undergone enhanced safeguarding training.
- Staff who participated in the focus group and ward staff demonstrated good knowledge and understanding of safeguarding vulnerable adults. They were aware of the process for reporting any concerns and could locate the policy easily for further guidance.

Long term conditions

- The hospital showed us that they have a system in place to monitor disclosure and barring service (DBS) checks that are made for all staff being employed. These were seen to be up to date at the time of inspection.
- We did not see records for PREVENT training or any awareness of understanding and reporting female genital mutilation (FGM). This should be considered as part of the safeguarding policy in accordance with national guidance.
- The hospital showed us that they were completing a safeguarding audit using the tool from the Surrey Safeguarding Board and this demonstrated a robust process for monitoring safeguarding concerns.

Infection control and hygiene

- We saw an infection prevention and control (IPC) policy was that was readily available to staff. Infection prevention and control training was mandatory and included in the induction programme and 82% of staff were up to date with this training. We were told the target is for all staff to have completed this training.
- Before inspection, we requested data about hospital acquired infection that had occurred between October 2015 and September 2016. We were told there was no screening data for Clostridium difficile (C.diff), Meticillin –susceptible staphylococcus aureus (MSSA) and Meticillin resistant staphylococcus aureus (MRSA). However, on the day of inspection there was a patient with suspected C.diff who was being nursed with appropriate infection control measures.
- The hospital monitored infection rates and had comparison data for five years. We saw that for the period January 2016 to December 2016 there were 64 reported infections, which included 29 chest infections, 13 urinary tract infections and 22 other. This number of infections is within expected range given the complexity and physical vulnerability of the patients. Data showed that in ten months of the year 2016 there were fewer infections than the preceding year.
- The hospital has an anti-microbial policy that states the rationale for prescribing, in addition we saw that reference was made to the 'Guidance for the management of infection', which was a formulary for prescribing which was available on the ward areas
- If advice was required from a microbiologist, there was a service level agreement. We reviewed this and saw it was with a local NHS trust hospital and contact could be made at any time.
- The director of nursing was the lead for IPC and we saw a completed plan for the two monthly meetings which covered incident reporting, surveillance, audit, training and the development of protocols.
- We were shown information about the IPC special interest group that comprised of clinical team members with a special interest in this area of practice. We saw evidence of a report the group submitted to the clinical governance committee.
- There was an annual plan for IPC and this reviewed the previous year's infection rate, compared rate and site of infection for the past five years and reflected objectives achieved. This document is completed by the director of nursing and submitted to the senior management team and medical advisory committee (MAC).
- The hospital completed a patient -led assessment of the care environment (PLACE), this is a system for assessing the quality of the patient environment. Patient representatives go into hospitals to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. In the PLACE audit, 2016 The Holy Cross Hospital scored 99.75% for cleanliness and 97% in relation to the general building maintenance of the hospital, which was much better than the national average of 93%. We saw a report on PLACE findings and actions to be taken was presented to the management team.
- Areas we visited around the hospital were tidy and visibly clean. We saw weekly departmental cleaning checklists were completed in all areas.
- Domestic waste bins were available and contained no inappropriate items. When asked, staff were able to

describe appropriate segregation of waste. This was in line with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to Health and Safety at Work regulations.

- In patients' rooms we saw that there were individual laundry bins with appropriate separation of items. Double bagging was observed for contaminated laundry. Each patient had an individual slide sheet that was used for manual handling manoeuvres. We observed that patient slings were initialled with patient details.

- Patient rooms were dust free and all fabrics in the room were wipeable in line with hospital building note (HBN) 00/09. The flooring was laminate with coved edges in line with HBN 00/10 part A (flooring).
  - There were good processes in place for sharps management which complied with Health and Safety (Sharp Instruments in Healthcare) regulations 2013. Sharps bins were clearly labelled with the temporary closure in place and tagged to ensure appropriate disposal.
  - We were shown that the hospital had a contract with a certified company for waste management. However there was no follow through process. It is a requirement for the customer to follow through the chain of disposal for assurance at least annually.
  - HTM 00-09 building note 3.42 states, "the location should provide clinical hand-wash basins and ensure that they were all readily available and convenient for use"'. We saw that there were hand basins available within the ward corridor and in the therapy rooms.
- We saw hand-sanitising gel was available at point of care in and outside patient rooms. This was in line with epic3: 'National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England' (epic3) and HTM 00-09. We saw staff using hand sanitizer when entering and exiting clinical areas.
- We reviewed a hand hygiene audit that was completed using direct observation and questioning of the staff. There was overall compliance of 96%. Areas of noncompliance were stated and recommendations made to address issues had been completed.
- On the ward we observed all nursing staff to be bare below the elbow in line with best practice. Personal protective equipment (PPE) such as disposable gloves, aprons and protective eyewear were readily available in all areas. We observed staff using PPE appropriately. One relative commented that staff always washed their hands and used aprons when delivering care.
  - We were shown an audit of clinical PPE. The audit was undertaken to assess practice in 19 areas related to the appropriate use of PPE in line with hospital policy. The methods included direct observation and questioning staff. The compliance rate of 98% noted that some staff were reluctant to use eye protection when there was a risk of splashing. Recommendations to improve practice were included in the audit.
  - HTM 00-09 section 3.133 for furnishings states: "soft furnishings (for example seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam free or heat sealed". We noted that all furnishings and chairs within the area used for activities was compliant with this requirement.
  - The patients are supported with specialist wheelchairs and we saw that these are subject to a daily cleaning regime and were wipeable and compatible with HTM 00/09.
  - All curtains within the patient area were labelled and changed every six months.
  - There was evidence of an up to date standard of operational practice for cleaning with a planned schedule in place. Cleaning staff were allocated ten rooms each and were encouraged to have ownership of these areas.
  - There were systems to ensure the safety of the water supply. We saw that legionella risk assessments were completed annually and this was last done in March 2016. All taps are checked twice a year in line with guidance and we saw that six monthly water testing was done to check for pseudomonas.
  - The hydrotherapy department was seen to be purpose built and was visibly clean and tidy. We were told that the maintenance team manage the pool and were shown daily water checks of pH, chlorine, water and

air temperature. The results showed these to be within expected ranges. An up to date hydrotherapy manual contained a current operating procedure for pool maintenance. This meant that staff were aware of processes and procedures in the management of the pool.

Environment and equipment

- We observed that the environment was generally in a good and tidy condition and corridors were kept free of clutter. The hospital is currently undergoing internal and external building works and we observed yellow warning notices were clearly displayed where work was being undertaken.
- The hospital showed us the process they had in place for regular equipment service checks from mainly external sources. The list was in the process of being completed with agreements in place for all equipment. The manager in charge was able to tell us the process and company responsible but was yet to complete a database containing a rolling schedule so there was assurance that planned preventative maintenance would routinely take place. After our inspection the provider advised us that they had expanded the database to capture the due date of next service.
- We saw that all equipment within the two gym areas and the hydrotherapy area had been serviced and tested, indicated by a label with the date tested. This provided a visual check that that they had been examined and were safe to use.
- The hospital has a medical devices committee which the director of nursing led and which was responsible for the safe management of equipment at the hospital. We were told that training of staff in the use of patient equipment is also managed by this group.
- The hospital had two tamper-proof resuscitation trolleys, one located on the first floor close to the ward area and a second trolley located in the hydrotherapy pool area. Both had weekly checks that were complete. When asked staff knew the location of the trolleys and had access to the equipment.
- The hospital was undergoing a process of having piped oxygen installed for patient rooms. At the time of inspection there were cylinders of oxygen kept within the patient rooms and in the corridors for easy access. We checked eight cylinders and they were all in date and safely stored.
- A number of patients were supported by the use of a ventilator, the records for ventilator checks were kept in a file on the ward. They were recorded as per room number, dated, timed and signed for. All equipment in the patient's room had dates showing when they were last serviced. We saw records that showed patients were checked every 15 minutes as well as the formal checks of the ventilator settings twice per day. Another specialised NHS unit working within a service agreement visited the hospital every three months to complete a service of the ventilators and we saw records of this.
- For ventilators we saw blue stickers with serial numbers were put in the patient's notes which were initialled and dated. Oxygen cylinders were checked once per day with the amount of oxygen left being recorded, signed and dated. In the clean room there were spare ventilators all marked as clean.
- We saw records that showed there was a monthly site inspection, including a check on lift function and panic alarms.

Medicines

- The hospital had a policy for the administration of medicines. The purpose of the policy was to make suitable arrangements for the recording, safekeeping, handling and disposal of drugs. We were told that no private prescriptions were kept on site.
- The hospital did not have an onsite pharmacy department. We saw there was a contract for pharmacy services with a third party for sourcing, delivery and management of medicines. This meant that there were adequate stocks of medicines to meet patients' needs. The pharmacy service also provided an out of hour's service to ensure medicines were always available if needed urgently.
- We were shown how medicines are ordered by the nurses electronically, the pharmacist visited once every two weeks. We noted patient medication charts were reviewed and stock checks were completed

Long term conditions

- Disposal of medicines were managed by the supplying pharmacy. We saw an audit trail of containers being checked, secured and collected with the process being checked and signed by two nurses.
- Storage of medicines was appropriate. On the wards, all medicines were stored securely in the treatment room. All cupboards containing medicines were locked and the keys were seen to be kept by the nurse in charge. On checking the medicines cupboards all medicines were in date with evidence of good stock rotation.

- All medicines including patients' own medicines were kept in the treatment room enabling the visiting pharmacist to check any medicines to be dispensed.
- Robust procedures were in place for monitoring and recording of ambient room temperatures where the medicines are stored and showed that storage temperatures were appropriate.
  - We saw that medicines were stored in dedicated medication fridges where applicable. Fridge temperature monitoring was done daily and when asked, staff knew what to do if the temperatures were found to be outside the recommended range. We checked a fridge and all medicines were in date and appropriately stored.
  - We looked at controlled drugs (CDs) which are medicines liable to be misused and requiring special management in wards. We found that the medicines were kept securely with controlled drugs (CDs) stored in suitable cupboards with records maintained. The CD cupboards were locked with restricted access. We checked order records, CD registers and found these to be in order. We saw that CDs were audited three times per month with no discrepancies noted.
  - The director of nursing is the Controlled Drugs Accountable Officer (CDAO) for the location and is not involved in the administration of medicines. They attended the local intelligence network (LIN) pharmacy governance meeting; minutes of one meeting were seen to include reporting a relevant CD incident at the hospital.
  - The hospital showed us a standard operating procedure for the management of controlled drugs dated February 2017. It was signed by the author and a signature list of those required to work within the protocol showing they had read the document.
  - We reviewed five medication charts. We found them to be legible and completed appropriately. Patient allergies were clearly noted on the chart. Reasons were stated for any medicines not administered and any errors were crossed through and signed. We saw that within the drug chart file there was information about the drug, mode of action and side effects as a prompt for nursing staff. The charts demonstrated that prescribing was in line with national guidance.
  - Guidelines had been developed setting out how medicines can be administered through feeding lines stating the first line of choice and second, these guidelines were readily available to the nursing staff.
  - Where appropriate, the patient was included in the administration of medicines and we observed a patient double-checking their medication with the nurse.
  - When completing the administration of medicines the nurse wore a red tabard indicating that she should not be disturbed. We observed that during medicine administration patients were appropriately identified. We saw that no medicines were left at the bedside which complied with 'Standards for medicines management' issued by the Nursing and Midwifery council (NMC).
  - Any medication errors were put onto the live electronic pharmacy system by the pharmacist and we observed that senior nurses on the ward recorded a response directly onto this system showing what actions were taken and lessons learnt. We saw that the hospital had a policy outlining action to be taken in the event of any medication errors with the first action being the nurse writing a reflective review of the incident. There was a clear escalation of actions to be taken if the error was repeated or of a more serious nature.
  - We saw that the live electronic pharmacy system was a valuable resource of information including medication alerts and up to date information; for

example the 'Guidelines for the Administration of Medication to Patients with Enteral Feeding Tubes or Swallowing Difficulties', that set out how to manage percutaneous endoscopic gastrostomy(PEG) feeding.

- We were told that all nursing staff must complete the medicine management e-learning programme and saw that 88% of staff had completed with only three staff members yet to undertake it.
- We noted that the hospital planned to introduce a medicine management special interest group which will report through to the clinical governance committee.

Records

- We saw that patient's records were multidisciplinary as doctors, nurses and therapists contributed to a single document. We saw that daily entries were made from the MDT. This ensured that relevant information was not omitted and that the entry was easy to follow and understand.
- We looked at 10 sets of patient records across the two ward areas and we saw notes were well completed and easy to navigate. The notes were comprehensive, contemporaneous and reflected the care and treatment patients received. They were generally compliant with guidance issued by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), the professional regulatory bodies for doctors and nurses. Patient records were readily accessible to those who needed them.
- The British Society of Rehabilitation Medicine (BSRM) recommends standards of best practice for care for patients with a complex neurological disability. Each patient should have a timed set of outcome goals that involve their family and is coordinated by the MDT. The goals should be reviewed at a frequency appropriate to the patient's management and be combined with appropriate outcome measures. We saw evidence in the notes of short and long-term goal setting from the MDT ward round and following the six to eight weekly MDT meeting when staff discussed the treatment goals with patient and relatives.
- Patient records contained information about the correct patient hoist to be used and there were photos within the records that showed correct patient positioning in the bed and wheelchair. This enabled the staff to be safe in their moving and handling and positioning of the patient.
- The hospital had an up to date health record and information governance policy. We saw that 91% of all staff had completed information governance training.
- We saw that a care plan audit was completed annually with a clear rationale and the results showed that 94% of notes were compliant with standards set. Two main areas of noncompliance were identified and an action plan was put in place.
- Patient records were seen to be stored securely at ward level and MDT notes were stored in a secured cupboard in an office secured with a keypad. Archived notes are kept on site in a secured cupboard with limited access.
- The hospital told us they are looking at identifying a customised electronic patient record system they felt would improve accuracy, sharing and accessibility.

Responding to patient risk

- We saw that patients were risk-assessed using nationally validated tools. For example, the risk of malnutrition was assessed using the Malnutrition Universal Screening Tools (MUST) tool and the risk of pressure damage was assessed using the Waterlow scoring tool. We saw that patient risk assessments were completed dated and signed.
- We saw in patients records that the risk of patients developing venous thromboembolism (VTE) was assessed on admission and reviewed by the MDT on the ward round, and assessment and treatment was documented.
- Staff we spoke to were aware of the national early warning scoring (NEWS) based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). This scoring system enabled staff to identify patients who were becoming increasingly unwell. We saw information in the ward area informing staff about NEWS scoring and all patient records using NEWS were seen to be completed appropriately

Long term conditions

- The hospital told us that between October 2015 and September 2016 a total number of three patients were transferred to another health care provider. Patients requiring intra venous antibiotics are admitted directly into the local trust intensive therapy unit (ITU) and had happened twice in the past year. Once treatment was complete patients returned to the hospital.
- We were told that all staff were trained in basic life support and the use of an automated external defibrillator (AED) and senior clinical staff had enhanced life support training, which included scenario training. There are three advanced life support trained staff. However there are no scenarios conducted at other times to test staff on their responses to an emergency and this should be undertaken.
- Pathology services were provided to the hospital by the local trust. We were told that results could take as long as a week to be returned and this might present a potential risk for patient safety in the case of abnormalities needing urgent attention. The arrangement with the trust should be reviewed with timeframes put in place for results to be returned to the hospital.

Nurse staffing

- Nurse staffing levels adhered to the recommendations as defined by national guidelines including the British Society of Rehabilitation Medicine (BRSM), the National Service Frameworks for Long term Conditions, the Royal College of Physicians Guidelines on Rehabilitation Following Acquired Brain Injury and the Royal College of Physicians Guidelines on Prolonged Disorders of Consciousness. These guidelines for establishment and daily staffing are used in conjunction with the safer nursing care tool (SNCT) endorsed by National Institute for Health and Care Excellence (NICE).
- We were told that the nursing staff establishment were reviewed annually and this was corroborated in the document submitted by the director of nursing 'Tools to calculate safe nursing staffing levels at Holy Cross Hospital', which showed calculation of current staffing establishment.
- We reviewed the current duty rotas for March 2017, which showed the actual number of staff working, matched the agreed number of staff on the rota.
- We looked back over a four-week period from February 2017 to March 2017 and saw the weekly fill rates for day shifts ranged from 109% to 90%. For night shifts for the same period the weekly fill rate was 97% or above. We saw that human resources (HR) department monitored fill rates. This meant overall staffing levels generally matched agreed establishment.
- Staff told us that enough staff were on duty unless there was sickness and that managers tried to fill those vacant shifts. The hospital had a number of bank nurses employed who filled shifts on a planned or ad hoc basis. We were told that most of those nurses on the bank are previous contracted employees who also completed mandatory training and clinical competencies to ensure they could meet the complex needs of the patients.
- On occasions agency staff were used. We saw documents that showed the human resources (HR) department monitored this usage, ensured staff that were used had completed an induction, competency assessments and had signed an awareness checklist. Regular feedback about their staff was given to the agency.
- We were told that there are currently 5.7 whole time equivalent (WTE) trained nurse vacancies. To address recruitment difficulties there has been recruitment of nurses from overseas. Two nurses we met told us they were 'well supported' through their induction and have stayed employed at the hospital beyond a two year period.
- Medical staff and patient's relatives we asked told us they felt there were enough nursing staff on duty.
- The hospital took student nurses from the local university for their clinical placements, but these staff were supernumerary to agreed staffing requirements.

Therapist Staffing

- The hospital had a therapy team that included physiotherapists. We reviewed the current service agreements for the occupational therapists (OT), speech and language therapists (SALT), specialist

dietitians and clinical neurophysiologists. There was evidence that these were reviewed bi-annually and that all checks including proof of identification, DBS, details of professional registration and personal indemnity were complete.

- We were told that the hospital took into account two sets of guidelines to ensure safe staffing. The Royal College of Physicians Rehabilitation following Acquired Brain Injury, 2003 and the British Society of Rehabilitation medicine 'Specialised Neuro-rehabilitation Service Standards' 2015. We saw that the hospital were meeting these standards using contracted and bank staff. There was no use of agency staff and no vacancies.

Medical staffing

- Patients care was overseen by a consultant in Rehabilitation Medicine employed through a service agreement, which we saw. He made weekly visits and was available at any time for phone advice. Staff confirmed that the consultant always responded to requests for assistance. In his absence one of the General Practitioners (GPs) would cover and this was confirmed by the GP and the nursing staff.
- There was a service level agreement, which we saw, with a local GP practice, which provided weekday daily doctor visits and a twenty-four hour on call service provided by a pool of seven doctors who are all familiar with the hospital's patients. The doctors attend in the capacity of visiting physicians and are not necessarily the patients' registered GPs. The practice has been providing this service for 23 years.
- Ward rounds were done every weekday and we saw there was an escalation plan for emergencies. We saw the visiting physicians visiting patients on both days of our inspection.
- There was an informal arrangement with the local trust hospital for patients to be admitted directly to the intensive therapy unit if required. Medical staff had access to a specialist tertiary NHS service if support was required in managing patients using with ventilator.

Anticipation and planning for potential risks

- The hospital provided us with a copy of their risk management policy, this included a section on responding to emergencies. In the case of emergency the senior staff on duty were directed to refer to the business continuity and critical incident plan. This plan was seen to detail what would be seen as a threat to the business and contained action plans for a range of scenarios. We saw records that showed desktop exercises with different scenarios were carried out by the senior team every three months.
- The hospital had its own generator in the case of electrical shutdown and we saw that weekly checks were made of fuel and oil to ensure it was ready for immediate use.
- The hospital also provided us with a separate fire policy. We saw records of weekly fire alarms and fire drills. We were told that the hospital did a drill using silent alarms with the night staff. The latest fire risk assessment was completed within the last six months and the next fire department visit was scheduled within the next month. A register of visitors was kept at main reception and would be used to account for everyone in the event of a fire. At ward report, we saw a member of staff was allocated as fire warden for that shift.
- The hospital had put in place individual evacuation plans for immobile patients and we saw two examples, these were complete with stated process and equipment needed. When asked, staff knew where to find and gave examples of equipment needed for specific patients.
- Therapy staff told us they practised a hydrotherapy emergency evacuation procedure three times a year and we saw records this was done on at least two occasions with a report produced of who was present, timings and training carried out.

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

Good

Evidence-based care and treatment

- We found care and treatment was delivered in accordance with national and international guidance and best practice.

- We checked ten hospital policies, and all relevant clinical policies were in date. We noted the hospital's policy frameworks were based on, and referenced national guidance and best practice. We saw examples of guidance from National Institute for Health and Care Excellence (NICE) being implemented.
- The hospital took part in the antimicrobial stewardship as part of the Antimicrobial Prescribing Stewardship (APS) competencies developed by the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) and Public Health England (PHE). The antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.
- Patients were assessed for venous thromboembolism (VTE) (formation of blood clots in the vein) as part of the admissions process. After patients had been admitted, regular review of VTE was a part of the multidisciplinary team (MDT) review. This was in line with NICE guidance CG 92 and CG 144.
- Patients with spasticity (a state of increased tone of a muscle; for example, spasticity of the legs has an increase in tone of the leg muscles so they feel tight and rigid and the knee jerk reflex is exaggerated) were supported with their condition using a combination of spasticity medication, hydrotherapy and Botox, to aid the relaxation of muscles and reduce pain. This was in line with the 2009 national guidelines 'Spasticity in adults: management using botulinum toxin'.
- Staff could refer to the hospitals Palliative Care Clinical Guidelines regarding advice for palliative care patients. The guidelines included information regarding symptom management as well as palliative care recommendations as detailed by NICE. Staff knew where to find the guidelines and when to seek assistance from senior staff and outside support agencies.
- Advanced care planning is recommended as an important aspect of holistic care planning by the end of life care strategy. However, we found very few patients had advanced care plans in place. Staff advised us this went against the ethos of rehabilitation. However, putting advanced care plans into place is considered best practice.

Patient outcomes

- We saw goals set for therapy for example when a patient was having hydrotherapy treatment. We saw there were patient screening and assessment forms which contained the goals of the therapy.
- We saw an auditing plan that listed upcoming audits and included details of the responsible person. Topics included; catheter management, tracheostomy management, positioning and splinting, use of beds/ mattresses/bed rails and care plans, which checked staff understanding as well as documentation standards.
- Audit results showed year on year the number of reported pressure ulcers was significantly less than other hospitals of this size. When we spoke to staff they advised us this was due to the MDT approach to positioning and that patients were checked on every 15 minutes. Therefore poor positioning was monitored and quickly rectified.
- On admission, patient outcomes were measured using a number of recognised tools. These were then regularly monitored by the MDT and care plans were amended accordingly. A few examples of the tools used at the hospital included; the Wessex Head Injury Matrix (WHIM), a scale to assess and monitor patient recovery after severe head injury, the Coma Recovery Scale Revised (CRS-R), is used to assess patients with a disorder of consciousness, commonly coma. It may be used to differentiate between vegetative state (VS) and minimally conscious state (MCS). Modified Ashworth Scale (MAS), measures resistance during passive soft-tissue stretching and is used as a simple measure of spasticity, Berg balance scale (BBS), clinical test of a person's static and balance abilities and Functional Independence Measure/Functional Assessment Measure (FIM/ FAM), used for measuring disability. The nature of patients comorbidities meant a lot of patients were at the hospital for the long term, although it is important to regularly review patient abilities, there was not necessarily improved outcomes for many years.

Long term conditions

- The hospital had acquired equipment to support the detection of early secondary conditions. For example, a bladder scanner was used to support detection of urinary tract infections as well as early signs of urine retention. We were given two examples where this equipment had supported the care and treatment of patients. The hospital also had a blood gas analyser (which measured the acidity and levels of oxygen and carbon dioxide in the blood. This test is used to check how well your lungs are able to move oxygen into the blood and remove carbon dioxide) that was used to provide quick results regarding blood gases and electrolytes. We were provided with examples where the testing had been used to wean a patient off a tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing).
- Guidance from the British Medical Association (BMA), the Resuscitation Council (RC) and the Royal College of Nursing (RCN) 'Decisions relating to cardiopulmonary resuscitation' states "Performance of CPR and the appropriateness and effectiveness of decisions about CPR should be the subject of continuous clinical audit." We reviewed the result of an audit dated March 2017 which demonstrated the overall level of compliance with the providers policy was 100%. There were a valid DNACPR decisions recorded and these were reviewed every two years. The last CPR attempt was made in 2014 and the audit demonstrated it was appropriate.
- The hospital had a list of patients that were Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Staff we spoke with did not know where this list was kept, however staff knew which patients were for DNACPR, which we confirmed via care plans and the DNACPR form.

Nutrition and hydration

- The majority of patients were fed using enteral feeding, (a way of delivering nutrition directly to your stomach or small intestine). However, several patients were fed orally or a combination of both whilst being weaned off the enteral feed. We saw nutrition care plans were developed in conjunction with a nutritionist and speech and language therapist (SALT) and reviewed monthly.
- Staff were only able to support the feeding of patients if they had completed nutrition and dysphagia training. We checked the staff files of staff seen supporting patients to eat and found they had completed this training. We viewed five patient records and saw that all had completed Malnutrition Universal Screening Tools (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. These were reviewed monthly as part of the care plan review.
- The dietitian visited the hospital twice a month and worked with the dietitian from the referring hospital to understand requirements before discharge. They then reviewed patients two weeks after admission and monthly from then on. NICE states reviewing of diet must be at least three monthly, therefore the hospital was more than meeting this requirement. Staff advised us they were able to contact the dietitian anytime if they had concerns.
- Patient records we reviewed showed staff monitored patient input and output. Staff knew when and to whom to escalate if a patients output was low.
- Information regarding the consistency of food and drink was documented in patients' care plans as well as the hospital kitchen. The dietician, lead nurse and Speech and Language therapist were all involved and a weekly updated list forwarded to all the professionals by the Speech And Language Therapist (SALT). We saw evidence of this communication.
- However, food was transferred to a preparation room where information such as; a list of patients who were able to support themselves, a list of patients who required soft/pureed food, number of scoops of thickener required etc. was not available. When we asked staff about this, they advised us they knew each patients nutritional requirements. An easy reference list could be useful to reference when supporting new members of staff.
- The hospitals in-house patients survey 2017 showed 93% of respondents felt food portions were sufficient for them, 93% of respondents felt the food and drink was of a quality they would expect and 85% of respondents reported that food arrived at an appropriate temperature.

Pain relief

Long term conditions

- Patients in need of palliative care were supported by a multidisciplinary team (MDT) to manage pain. A consultant in rehabilitation medicine was present at weekly ward rounds and supported the review of pain medication. Staff could access support and advice from the local Macmillan team, there was 24-hour support from the therapy team who assisted patients with pain through posture management and hydrotherapy. Staff used the World Health Organisation (WHO) Analgesic Ladder (2015) to assess the pain needs of palliative care patients.
- At the time of inspection, the majority of patients were prescribed regular analgesia (pain relief) such as paracetamol. If patients required further pain relief, staff used a visual analogue score (a measurement instrument used to review levels of pain by assessing subjective characteristics that cannot be directly measured) if the patient was able to verbalise. If a patient was unable to verbalise, staff reviewed levels of agitation, sitting duration in wheelchair, time spent in a splint etcetera. We saw care plans which confirmed health care assistants (HCAs) checked patients every 15 minutes. If during a check a patient appeared or advised they were in pain, staff escalated the issue to a nurse.
- The hospital held a two-day workshop in conjunction with Know Pain, to look at managing long-term pain in patients. The workshop included looking at; discussing pain with patients, looking at evidence based theories of pain and practical implementation.
- The hospital was developing a specialst pain scale in conjunction with the University of Liege in Belgium for use with patients with profound neurological impairment.
- Staff did not have the training skills to use a syringe driver (a small infusion pump used to gradually administer small amounts of fluid, with or without medication). When we spoke to staff about this, they said the Macmillan team supported the use of syringe drivers and therefore they did not need to use them. However, we saw patient notes that suggested use of a syringe driver would have been beneficial in supporting patients 'care.

Competent staff

- The Nursing and Midwifery Council (NMC) and Health Professions Council (HCPC) requires nurses and allied health professionals to maintain registration with them in order to ensure standards of practice. At Holy Cross Hospital, the management team had checked the registrations of nurses, therapists and other allied healthcare professionals using an electronic system that was demonstrated to us. Within the last 12 months, 100% of applicable staff has their registrations checked. Therefore, the hospital could be assured their staff met NMC standards.
- We reviewed the service level agreements held by some therapy staff. We noted they contained checks of the practitioner's qualifications and registration status that were current.
- Staff were supported with revalidation by the Director of Nursing and had access to support information regarding how to complete the revalidation process and how to provide examples of best practice.
- Staff within the MDT had specialist skills including; advanced respiratory management, botulinum toxin injection therapy (Botox), as well as 24-hour posture management, spasticity management and respiratory management. Ward staff used them as a source of information and stated the knowledge within the MDT was a "useful resource".
- All staff received training to keep them up-to-date in developments including attendance at the national disorders of consciousness conference hosted by the hospital, brain injury and objective assessment of disorders of consciousness, respiratory management, nutrition and dysphagia, care planning, 24 hour posture management and splinting.
- Special interest groups had been developed by the hospital and were made up of clinical team members with a special interest in the area concerned. The purpose of the groups was to promote best practice based on recent developments and evidence. Members of the group supported staff in other clinical teams through coaching and as a point of contact for advice. Areas covered by the special interest groups included; respiratory management, dysphagia and nutrition, posture and positioning, tissue viability and wound management, continence, disorder of consciousness and end of life care.

Long term conditions

- There was a competence framework for registered nurses and health care assistants. Senior nurses assessed the competences of nursing staff relevant to their role and responsibilities. All staff files we reviewed had completed competency frameworks.
- New members of staff underwent a two week induction period and were expected to demonstrate competences in several key areas relevant to their role, for example, manual handling, knowledge of patients and administration of medication. Reviews were undertaken after one and three months with the latter focusing on personal development. Competences were assessed on completion of induction. At the time of inspection, 100% of staff had received an induction.
- Senior clinical staff received clinical supervision from an external supervisor on a two monthly basis. Senior staff provided clinical supervision to junior staff on a two monthly basis. Supervision consisted of one to one's or groups where the group was formed of staff on a similar grade.
- The hospitals in-house patient survey 2017 showed 96% of respondents always or mostly had trust and confidence in the staff looking after them. This indicated good, trustful working relationships between staff, patients and their families.
- Between October 2015 and September 2016, 48.4% of nurses, 86% of therapists and 80.6% of HCA's received an appraisal. Therefore, there were reduced assurances that nurses at the hospital had opportunities to discuss professional development and working practices with senior members of staff. We saw records during the our inspection visit which showed the appraisal rates for nurses had improved to 79%.

Multidisciplinary working and coordinated care pathways

- Each patient had a member of the MDT allocated to them as their key worker. The key worker role included being a point of contact across systems, ensuring care plans were adhered to and being an ambassador on behalf of the patient. One member of staff described the role as "How can I make this patient's life better."
- There was a weekly ward round every Tuesday on alternate wards. We observed a ward round and noted there was input from the whole MDT including therapists. Each patient was spoken to individually to discuss any issues and review pain.
- Patient handover was at 1.30pm which included all staff. Handover was used as an opportunity to assess the patient's day. Nurses or care assistants managing the care of the patient discussed the care given that morning and any issues or concerns. Any specialist referrals were discussed as well as family issues and any activities the patient had been involved in. Changes in skin condition were mentioned and any impact this would have for planned activities the next day. The handover was also an opportunity for the Sister to discuss any training or learnings from incidents.
- After six weeks of being at the hospital, patients received a full MDT meeting that included family. After this time the MDT set up goal setting meetings every six to eight weeks. The purpose of the meetings was to support patients regarding changing priorities and ensure the whole team had up to date information regarding a patient and that aims were shared across teams.
- There were quarterly meetings with the Macmillan team to discuss patients on an end of life care pathway and review any changes to policy and planning. This gave staff the opportunity to keep current with best practices.

Access to information

- Staff we spoke with knew where they could access the policies and gave us examples of when they would refer to them.
- Turnaround times of blood tests was about a week. However, we could not find any evidence that this delay effected patient safety or the hospitals ability to respond to patient need.
- All external information, for example information being sent to a GP, was reviewed by the information governance lead to ensure it met standards of the Data Protection Act 1998 and was sent via secure methods.

Outstanding ☆

Long term conditions

Consent, Mental Capacity Act, and Deprivation of Liberty Safeguards

- We viewed the hospitals consent policy, which referenced all relevant legislation such as; NICE 'Guidance on informed consent', the Mental Capacity Act 2005 'Code of practice', General Medical Council 'Guidance on consent' and the Nursing and Midwifery Council 'Code of professional conduct'. The policy provided information on the five core principles regarding capacity, where to get support regarding making best interest decisions, advice on when to seek consent, what documentation was required by law, as well as information to support staff when a patient refused treatment. All staff knew the contents of the policy as well as how to access it.
- We checked five patient records and noted all contained relevant consent forms. Where there was a Deprivation of Liberty Safeguard (DoLS) in place, care plans included a best interest statement, a signed standard authorisation with an upcoming review date and all documentation referenced the Mental Capacity Act 2005 (MCA). DoLS provides protection for vulnerable people who are accommodated in hospitals or care homes who lack the capacity to consent to the care or treatment they need.
- Staff knew their responsibilities under the MCA and DoLS to make best interest decisions for patients who were unable to give consent. Best interest decisions were made by an MDT where applicable and included input from families. We saw staff refer to 'Getting to know me' forms when making day-to-day best interest decisions. For example, staff used photographs to dress and style a patient in order that they presented in the same style as they preferred before their injury.
- We saw that the hospital had guidelines in place for the covert administration of medicines and stated that patient consent was essential but recognised that where best interest decisions were necessary this would be made by the multi-disciplinary team including pharmacist, medical and nursing staff.
- At the time of inspection staff completion rates for MCA/DoLS training was 91%. Therefore, there was assurance staff knew the legal processes for supporting a patient who lacked capacity and their responsibilities regarding best interest decisions.
- Staff used communication equipment in the sensory room to support patients with difficulty in verbalising their choices to ensure patients were able to consent themselves rather than have a best interest decision made for them. Therefore, staff were using all available resources to ensure patients had the opportunity to consent, rather than solely relying on staff making best interest decisions.

Are long term conditions caring?

Outstanding ☆

Compassionate care

- Patients were truly respected and valued as individuals. All staff were passionate about their roles and were very dedicated to making sure patients received the best patient centred care possible.
- Feedback from patients and those close to them was continually positive and care received exceeded their expectations. We reviewed results from the hospitals most recent patient experience surveys and found the feedback was very positive and the ratings were high. For example, the 2017 survey showed 96% of respondents always or mostly felt that all staff had a shared understanding of their needs and 96% of respondents felt that they are always treated with respect and dignity. In addition, the hospital provided us with the results of the annual patient survey 2017 based on an NHS standard survey. There was a 60% return rate with 20% completed by patients, 76% by relatives and 4% by others. Overall, the responses showed 92% of all respondents rated the hospital at the top of the four-point scale and 84% gave the highest rating for care and attention provided by nurses and carers while the remainder gave a score of three.
- CQC received numerous comments from families that overwhelmingly described the caring and compassionate attitude of the staff. For example, a few comments stated; "The care, respect and understanding my daughter and us as a family receive is absolutely second to none." "Wonderful place, wonderful people, great care!!" and "After 40 years [of our son being in care], Holy Cross is the best hospital for patient care and attention. Staff treat him with dignity."

Long term conditions

- During inspection, we spoke with six patients who all described staff in a positive, empathetic light. For example, comments included "Staff are lovely", "Really nice and polite" and "I would not have got where I am without the support of all the staff here, they are wonderful, I cannot fault them. They have supported me throughout my journey and really took time to understand my worries and concerns."
- The hospitals 'operational standards' detailed the standards staff were expected to work towards. The standards included ensuring patients' privacy, confidentiality of information and working with integrity. These standards were displayed throughout the hospital in order that patients and families knew the standards they could expect from staff. We saw all staff adhering to these standards during care and treatment of patients and interactions with families. Staff knew the standards and understood the importance of holistic care.
- We observed patients were always treated with dignity, respect and kindness during all interactions with all staff, and relationships were characterised between staff, patients and those close to them as strong and caring. For example, we observed staff always knocked on patients' doors before entering.
- Patients and staff provided us with numerous examples of where staff had gone "Above and beyond". For example, a patient who had been transferred to an acute hospital found the environment very distressing and hospital staff found it difficult to communicate with them. Therefore, staff from Holy Cross Hospital visited the patient every day, assisted with personal care, ensuring the patient was looked after by people they knew and supported hospital staff to communicate and understand how best to communicate with the patient. One patient told us that if you had been away from the hospital for a period of time, staff put up welcome home banners, had a tea party with you on your arrival and a member of staff was allocated to ensure you "Settled back home ok."

Understanding and involvement of patients and those close to them

- Patient's individual preferences and needs were always reflected in how care was planned and delivered, we saw staff support patients to make own choices on clothes, hairstyles, weekly shopping, visitors and others. Patients were supported to choose their own food on advice of dietician and speech and language therapist (SALT), select preferable social outings (for example, theatre and seaside trips) or arrange own outings (for example, home visits). Where patients lacked capacity, staff used photos and information garnered from patients 'Getting to know me' forms to inform them of the preferred style of the patient and support which items they bought during shopping trips.
- Staff explained to patients what they were going to do before proceeding and spoke in non-medical jargon. Staff gave patients choices as much as possible, we observed a staff member supporting a patient to eat. They asked the patient what aspect of the meal they would like to eat next, for example, potato, beef or broccoli. We also saw staff adapting the environment to support patient choices, for example a patient wished to be positioned on their left so they could see the door whilst waiting for visitors, however in the meantime he also wanted to watch television. Therefore, staff arranged the bed in order that the patient could see both.
- Patients were considered active partners in their care. Patients and their families were fully involved in the goal setting process and their wishes and opinions are embedded in the goals set. Patients were also involved in the risk based care planning process, which enabled them to be in control of their management plan. Families were supported when they wanted to get involved with day-to-day care needs such as support with eating. One family commented, "We are pleased we have the opportunity to help with some of his care without compromising hospital controls."
- Patients with capacity were fully involved in their treatment and care planning, for example, they had the option to attend goal-setting meetings. A patient we spoke with said this enabled them to be confident in taking control of their own health. We also saw evidence of patient involvement in the decision-making process regarding transfer to acute hospital, palliative care and DNACPR requests.

Long term conditions

- It was clear when speaking to staff and patients that patients were fully supported to be empowered and to take charge of their health when at all possible. Patients and families told us staff focused on the patients' needs. All parties felt involved in discussions about care and treatment options and told us they were confident asking questions.
- Families of patients who lacked capacity were provided with a 'Life story post injury book' in order to compile their relatives' life stories after their injury as well as a 'Getting to know me' form which detailed interests and preferences which staff used to support care and activity planning. Families were also fully involved in patient care and treatment and were invited to attend regular family meetings where care, treatment and progress were discussed. Families also contributed to the relatives' weekly activity timetables which we saw minutes of. Families we spoke with said they appreciated this and it also ensured activities they knew their family member would enjoy were taking place.

Emotional support

- Patients' emotional and social needs were highly valued by staff. Staff showed a great understanding of the impact the condition and treatment had on patients and this was embedded in their care using a multidisciplinary approach. For example, staff supported patients and their families in the first instance, however referrals to other services such as counselling services and chaplaincy, could be made if further specialised support was needed. We saw staff had good relationships with patients and families and families told us they felt confident in asking staff for support from external agencies when they felt it was needed. For example, a clinical neuropsychologist regularly attended the hospital and was available to assist patients, families and staff.
- Patients in need of palliative care received psychological support from the clinical neuropsychologist and other local counselling services from outside the hospital, such as Macmillan.
- Patients were supported when they needed to be transferred into an acute setting. For example, staff visited an anxious patient daily when they were in hospital in order to provide assurance, communicate more effectively and ensure the patient had regular contact with someone they knew.

Are long term conditions responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

We rated responsive as outstanding.

Planning and delivering services which meet people's needs

- Services were tailored to meet the needs of individual patients, people with neurological conditions more generally and the local community. They were planned to deliver maximum flexibility and choice.
- If families and friends wished to stay overnight in the local area, staff were able to arrange accommodation at the convent or families could stay in the homes of 'Friends of the Holy Cross' who lived in Haslemere and the local area. Families we spoke with said this was greatly appreciated, especially during times when a patient was in ill health.
- Visiting times at the hospital were 10am to 8.30pm daily. This gave flexibility to patients' friends and families, and families we spoke with appreciated this as many of them visited daily. Therefore, they could work visits around their home life.
- The outpatient Physiotherapy Centre provided physiotherapy support and classes which members of the public could access directly or be referred. Patients received an initial assessment and could then access either 1:1 treatment such as acupuncture or join one of the exercise classes such as pilates or hydrotherapy. This showed the hospital provided a service that would otherwise not be available to the local community.
- The environment had been planned and adapted to support the needs of patients and encourage participation in everyday life at the hospital. Patients were empowered to get as involved as they wished

regardless of level of disability and the environment supported this. For example, corridors and doors were wide enough that patients who were bed bound could attend activities in the activity room. There was an ethos of patient ownership regarding the environment, as all art displayed within the hospital had been painted by patients. In addition, patient bedrooms were personalised as much as possible. A member of staff said, "This is their home."

- The hospital held regular stroke meetings in the activities room for members of the public to use as a means of support and have regular contact with other people who had either suffered a stroke themselves, or had a family member who had a stroke.

Meeting needs of different people

- There was a proactive approach to understanding the needs of patients. The hospital participated in national and international research studies designed to improve the understanding of the needs of people with acquired brain injuries, and to develop techniques and strategies to meet those needs. The management team told us they were proud of their developments in learning and development and in the last year have put on a national conference relevant to their specialist field of care, which was attended by internal and external delegates.
- There were innovative approaches to providing patient centred care. We found numerous examples of where the hospital had utilised state of the art technology as well as using simple activities and the environment to best meet the needs of patients and provide a living environment that was "Not just a hospital, it is their [patients] home."
- The St Anne's sensory room was an example of how the hospital and staff supported and empowered patients with very little mobility to interact with their environment, other people and make their choices and opinions known. The room included a 'magic carpet' that used eye gaze software (using the direction of a person's gaze to detect the point on which a person's eyes are focused) to enable patients to play games and interact with projected pictures. The room also had optobeam technology where patients with limited mobility could interact with beams of light that triggered reactions on a projected animation. Staff used this technology to communicate with patients. Patients could answer yes and no questions by responding in one of two ways. This empowered patients with even the most limited communication skills to let their opinions be heard.
- The activity room was big enough that it could be easily divided into several areas in order that numerous activities could take place at the same time. Activities were usually divided into two with one area focusing on more sensory activities and another for more mobile/active patients. We saw patients joining in a singing session in the morning and watching a film they had chosen in the afternoon. As well as one to one sessions where books were read and jigsaw puzzles completed.
- The activity room included a therapy kitchen, which although not in use during the inspection, patients advised us they enjoyed using the facility and it made them feel "More like normal." It also supported patients to live more independently and prepare for when they moved back into the community.
- A chapel was open 24 hours a day, seven days a week. It was available for use by patients, families and staff. We were advised people from any religious background could use the chapel. However as this was a Christian institution the chapel displayed Christian symbols, therefore people who wanted a different quiet environment could use other rooms such as the sensory room.
- There was a sensory garden that included a fishpond with waterfall, plants of varying colour and scent and a terrace. Staff advised us the garden was planned to be stimulating to all five senses and patients said it was a calm area to relax in and appreciated the environment.
- Although the hospital provided rehabilitation facilities, staff understood some patients would be at the hospital for a significant period of time and the social impact this would have. Therefore, safe environments had been created away from the hospital itself. For example, there was a woodland trail outside the hospital that was wheelchair friendly and provided

views over the countryside. Patients and family we spoke with said they appreciated having somewhere quiet they could spend time together that was near medical assistance if it was needed.

- Patients also had access to a holiday cottage in Selsey. Trips were regularly organised and gave patients a safe, adapted environment to see family and friends away from the hospital. One patient advised us they liked the cottage as it was easier for their family to travel to Selsey than to Haslemere. We were impressed with the regularity of these trips considering the logistics needed to undertake them. When we spoke to staff about this they understood the benefit to the patients and were "Happy we can support them in this way."
- There were in-house facilities that enabled patients to have regular visits from a hairdresser. This supported patients to have a sense of self, take pride in their appearance and take part in everyday activities.
- The hydrotherapy pool was commissioned when another local hydrotherapy pool closed down and the hospital recognised there was a need for this service not only for their own patients but also for those that wanted the service within the local community. The patients' group, which was made up of patients' relatives requested that the opening hours of the pool be increased at weekends. This was being considered at the time of our inspection.
- Occupational therapists assessed patients' needs and provided equipment in order to empower patients and support independence. For example, we saw adapted cutlery to support patients to feed themselves, there were numerous types of call bell in order that patients could seek assistance when required. Television remotes were also adapted so patients could change the channel independently without the need to ask for assistance.
- Staff had access to registered translation services to support understanding in patients whose first language was not English, not all staff knew this service was available, however at the time of inspection there were no patients who could not speak English. Other staff advised us they would use patients' family to convey information; however, this is not best practice as there is no assurance of understanding.
- Two nurses from the hospital had completed a European Palliative Care (EPC) course. The aim of the course was to support pain management as well as build relationships with outside agencies such as hospices. The nurses worked with the Macmillan team to compile end of life care plans and were available as a resource for other staff.
- Staff, patient and the public could access information regarding the hospital through various newsletters including; Friends of Holy Cross newsletter and a Holy Cross Centenary newsletter that provided updates on St Hugh's, a new education centre being built on site. These were available on the hospital website.
- The website also provided information regarding what families and patients due for admission could expect on the day of admission, including details of any assessments, care planning and rehabilitation plans, as well as plans for meeting the clinical team. Families we spoke with advised us this was helpful in alleviating fears in the run up to admittance.
- In outpatients and the physiotherapy centre we found information leaflets for a variety of different ailments that were from recognised institutions such as Arthritis Research UK. We checked 10 different leaflets and all were in date. Therefore patients could be assured the information they received was current and from a reliable source.

Timely care and treatment

- There were arrangements to ensure patients could access services that could meet their complex needs in a reasonable period. A pre admission assessment was completed by senior clinicians in order to identify clinical needs and risks, and to ensure the MDT could meet patient's needs. The findings from the pre admission assessment were shared with the multi-disciplinary team and the consultant in rehabilitation medicine before a final decision on admission was made. The patient and their family were encouraged to visit the hospital before finalising their decision. If all parties agreed, the patient was then placed on the waiting list. In the event there was

no likely prospect of bed becoming available for more than three months, all parties were advised which allowed alternative options to be pursued. At the time of inspection, there were two patients currently on the hospital waiting list.

- The multidisciplinary team including doctors, nurses, speech and language therapists (SALT), occupational therapists (OT), physiotherapists (PT), psychologists and dieticians assessed patients prior to admission. On admission, a comprehensive assessment was carried out to identify problems and list rehabilitation goals.
- Discharge planning was carried out in consultation with the patient and the family. Before discharge the MDT compiled a report of patient's needs and identified a suitable discharge destination, for example family home or care home. The therapy MDT assessed home environments and ensured all necessary equipment was in place, they also worked with community services to ensure care packages were ready for discharge home. For example, the team worked with care agencies and social services in order to provide a seamless service from an acute to community setting.

Learning from complaints and concerns

- Information on how to complain was easily available on the hospital website. The complaints policy and procedures were also detailed in the patients' guide folder and copies were available in reception and outpatients. Patients we spoke with knew how to complain and advised staff were very good at resolving any issues they had.
- Hospital staff aimed to resolve concerns before they became formal complaints, this reflected the small number of complaints received at the hospital and shows the strong working relationships between staff, patients and their families. Managers practised an open door policy and were frequently around the hospital and available for informal discussion with patients and families. The director of nursing made daily visits to every patient to check there were no issues or concerns.
- The management team had clearly defined roles regarding who had responsibility for handling and responding to complaints.
- From October 2015 to September 2016, there were six written complaints at the hospital; however, these were not formal complaints. All received a full response within 20 days as detailed in the hospitals complaints policy.
- The hospital maintained a register of compliments and complaints received as well as any actions taken and the outcome. The management team compiled the information into an annual report which was forwarded to the relevant NHS body and to the Care Quality Commission. All new entries in the register were reported to the MAC for review, comment and if necessary implementation of new practices.
- From the six complaints there were no discernible themes, although the management team actively reviewed complaints and made amendments accordingly. For example, one patient complained about being cold, therefore a contractor was called to investigate and a fault was found and corrected. In another example, staff breaks had been spread out in order that requests for assistance could be responded to more effectively.
- The hospitals in-house patient survey 2017 showed 96% of respondents always or mostly felt that their concerns or complaints were addressed and responded to by staff. A family member advised us "[Staff] listen to any concerns we have and respond appropriately."

Are long term conditions well-led?

Good

We rated well-led as good.

Leadership and culture

- The hospital achieved the Investors in People award in 2016 for the sixth consecutive time. This national award was in recognition of the hospital developed, supported and motivated staff.
- The structure of the management of the hospital consisted of a chief executive who was answerable to the trustees of the hospital. There were departmental directors for clinical services, nursing, finance,

information services, human resources and general management. Once a month the whole team met together as heads of departments. The management team reported to the trustees every six weeks.

- The chief executive described inter- professional relationships at the hospital as 'excellent' as management and staff all know each other.
- The human resources manager was the nominated speak up guardian. Staff said they were aware of whistleblowing policy but felt able to speak directly to colleagues if there were any issues to be addressed. We saw records that showed staff had approached the speak up guardian when there were concerns and that appropriate support was given. This demonstrated that there was an open culture and staff told us they felt supported when they raised concerns.
- Staff described the hospital as being well organised with good support from the management team.
- Staff talked about 'knowing each other well and working together as a team', Staff told us they felt valued. One staff member said they were able to work, flexible hours, 'liked the calmness, was able to deliver care properly and did not have to cut corners', had regular breaks and did not feel stressed or under pressure. All staff commented on the productive working together of the multi-disciplinary team.
- Staff told us they feel that they make a difference to their patients, A member of the cleaning staff told us they understood the importance of their role, as patients were 'vulnerable to infection'. This demonstrated that there was a shared purpose throughout the workforce.
- We saw an example of where conduct had fallen below accepted professional standards had been managed appropriately and robustly. This showed the hospital management team did not tolerate unacceptable conduct.

Vision and strategy

- The hospital told us the values of the hospital were developed by the religious order that first established the hospital and this has been passed on over the years as an enduring mission statement to serve people who are sick or suffering and their families. Staff we spoke with were very positive about this approach and talked about their ability to make a difference to the patients. They spoke of the religious founding of the hospital and the beliefs in 'doing what was best for the patient'. We observed that staff were caring and compassionate and made constant reference to patient's and family members as they planned and delivered care
- The strategy of the hospital was to "be a centre of excellence for people with disabilities resulting from neurological injury or illness and meeting the needs and expectations of patients and their relatives". The Clinical Outcomes report 2016 described the hospital plan to be the improvement of hospital services, increasing knowledge, skills and efficiency.

Governance

- There was a governance framework in the hospital that gave assurance about the quality and safety of services. The hospital held meetings through which governance issues were addressed, the meetings included the Medical Advisory Committee (MAC), clinical governance meetings and monthly heads of department meetings.
- We saw that the hospital had a robust clinical governance framework document that detailed all reporting lines and who held professional responsibility for decision making at different levels of the organisation. In addition to this, there was a clinical governance annual plan for the year, which included an audit programme, measurements of effectiveness, risk management, staffing, a learning and development and service plan.
- There were eight special interest groups forming part of the governance framework covering areas of potential risk and development such as infection prevention and control, posture management and tissue viability and wound management. These groups had a planned set of objectives and reported through to the senior management team. Teams are to be added as a need is identified. We saw that medicine management is soon to be added.
- The MAC had representation from the GP's who provided cover for the hospital, the consultant in rehabilitation medicine and the senior hospital team. The hospital provided terms of reference for the group.

We saw minutes of the meeting which showed it met quarterly. The directors of nursing and clinical services produced a governance report that was reviewed and discussed at this forum.

- The hospital provided us with a risk management policy which showed the categories under which risks were assessed and saw that risk is a standard agenda item on the governance meeting agenda.
- Each ward sister or department lead monitored risk in their own department. On the ward, we saw completed risk assessments for the environment and equipment. We were told that staff are getting more training on completion of risk assessments. However, the risk register is a list of assessments with links to supporting policies. There was no clear risk rating based on likelihood of occurrence and severity of outcome, or priority for each risk. Mitigating actions were to be found in the supporting policies and were not individualised to the specific risk identified. There was no system for escalating risks based on their risk rating from a local to hospital wide risk register. This meant there was no assurance that the senior management team had awareness of key risks across the hospital. This was discussed with the management team at the time of inspection.
- Medicine management was seen to be a standing agenda item at the MAC and governance meeting. Medicine and healthcare products regulatory agency (MHRA) alerts and the NICE guidelines are available on the live pharmacy system. Meeting minutes we reviewed showed these were regularly reviewed and circulated. When managing medicine errors, there was clear evidence that appropriate procedures were followed when necessary.
- There was a wide range of audits carried out in the hospital and there was evidence that these were reviewed within the governance meetings. There was a regular audit plan for the hospital and we saw they were up to date with the plan.
- On checking personnel files, it was found there were incomplete work histories for staff required in line with schedule 3 of "The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Information required in respect of Persons Employed or Appointed for the purposes of a Regulated Activity". However, this was discussed with the management team and the next day the files had been updated and the process of obtaining the information had been adapted to ensure all requirements of schedule 3 were met.

Engagement and involvement

- We saw minutes of the monthly patients' forum from September 2016 to December 2016. Patients used the forum to put forward ideas regarding upcoming activities. Staff also used the forum as an opportunity to update patients and families regarding ongoing developments at the hospital such as building work for the new education centre.
- Staff described the hospital as a happy place to work. Ideas could be put forward and staff felt they would be listened to and suggestions will be acted on. They were encouraged to look outside of the organisation to source relevant information and to compare practice.
- One manager spoke about the importance of engaging staff at induction and how this was reinforced in the delivery of clinical outcomes. We were told that at the start of projects, a consultation letter would be sent to staff and relatives to engage and involve them. We saw the letter that was sent about the capital project to install piped oxygen and suction to patient rooms. The letter invited staff feedback on this project.
- Staff spoke positively about the continued development of the hospital including the building of a learning centre and felt they had been consulted and kept involved with this project. They said they were pleased that this building would be open to external organisations.
- We saw examples that showed families were actively consulted and involved in their relatives care and with development of services at the hospital. The patients group for relatives was a meeting used to discuss any hospital wide concerns, clinical representatives attended the meeting and minutes are taken.In the meeting minutes an example of how this group can influence care was seen as relatives had asked for an increase in the number of hydrotherapy sessions and we were told this was now being considered.

Long term conditions

- The hospital supplied minutes from the monthly patient forum group which was attended by patients, relatives, staff and volunteers which showed discussion about daily and weekly activities for the patients and families.
- We were told that the hospital was in the process of installing piped oxygen and suction to each patient room. We saw that staff had been emailed and asked for their comments on this project before it was started and staff feedback was shared with the relevant managers. In addition, there was a letter to all patients and relatives detailing plans of the project, the benefits of the piped oxygen and suction were given and level of disruption anticipated. The letter asked for feedback and comments. This demonstrated genuine engagement with patients and those close to them.
- The monthly hospital newsletter included information on the upcoming plans including the current building work. The newsletter gave details of the 'you say' sessions. The head of department meeting minutes supplied showed feedback from these sessions being discussed.
- The hospital management team spoke positively about the support they received from volunteers who belonged to the Friends of Holy Cross. During our inspection we spoke to volunteers who were overwhelmingly positive about their contribution and involvement at the hospital and told us how much they enjoy being part of the volunteer team. We saw the hospital clinical report acknowledged the volunteers contribution to the hospital and saw there were regular committees meetings and an annual general meeting.
- We saw the Queen's Award for Voluntary Services displayed near the activity room. The Queen's Award is the highest award given to volunteer groups across the UK. In order to be eligible volunteers must provide a service and meet a need for people living in the local community, be supported, recognised and respected by the local community and the people who benefit from it and be run locally. Volunteers were rightfully very proud they had received this award.

Continuous improvement

- The hospital was at the forefront of disorder of consciousness medicine and held a conference on multidisciplinary management of people with a disorder of consciousness every two years. The hospital clinical and management team invited clinical and academic experts to attend and provide information and learning on both medical theory and the practicalities of implementing practice.
- The hospital was at the forefront of practice in that it was developing pathways for other institutions to use. For example, staff from the hospital had been invited to co-write Royal College of Physicians guidelines regarding physical management as well as set up a patient group as part of an excellence centre. The National Skills Academy for Health is developing a network of Excellence Centres across England to bring together employers from the NHS, independent and voluntary sectors to coordinate and implement high quality skills programmes.
- The director of clinical services had received a scholarship to work with a hospital attached to Harvard Medical School to look into long-term acute care in minimally conscious patients. This demonstrated that clinical leads were at the forefront of care for specialisms within the hospital.
- The hospital was working with global leaders in the treatment of disorder of consciousness patients such as, Northwick Park Hospital, Cambridge Coma Centre, the Royal Hospital for Neurodisability and Keele University to develop disorder of consciousness pathways.
- We saw examples of staff being encouraged to develop their knowledge in the specialty and to publicise their achievements. The hospital hosted a two-day national conference and told us that they saw this as an opportunity to strengthen networks with clinicians, academics and researchers.
- We saw there was active service evaluation and research activities undertaken by one of the senior managers with publication expected this year. The hospital was actively involved in the development of good practice treatment guidelines for the multidisciplinary team.
- To support the opening of the new educational suite which we saw was under development we saw there

are plans for an inaugural event to host a 'supporting families of people with severe and complex brain injuries: What can professionals do'. We were told the aim was to share experience and discuss what training is required.

Outstanding practice and areas for improvement

Outstanding practice

- People were truly respected and valued as individuals and were empowered as partners in their care. There was an emphasis on providing a care setting that patients could consider their home.There was an embedded culture of caring amongst all staff and we saw many examples of staff going the 'extra mile'. Services were planned and delivered to afford maximum flexibility and choice for patients and those close to them.
- The hospital was at the forefront of care for people with long-term conditions and disorder of consciousness medicine. Staff from the hospital had been invited to co-write Royal College of Physicians guidelines regarding pain as well as set up a patient group as part of an excellence centre. The hospital was developing a specialist pain scale in conjunction with the University of Liege in Belgium The hospital hosted a national conference on multidisciplinary management of people with a disorder of consciousness twice a year.
- When patients needed acute hospital care, there were arrangements for staff from Holy Cross Hospital to support patients in this environment, and also to support other professional staff in meeting the complex, individual needs of patients. Patients were welcomed when they returned.
- The hospital was using cutting-edge technologies to improve care of patients. The St Anne's sensory room had a 'magic carpet' that used eye gaze software (using the direction of a person's gaze to detect the point on which a person's eyes are focused) to enable patients to play games and interact with projected pictures. The room also had optobeam technology where patients with limited mobility could interact with beams of light that triggered reactions on a projected animation.
- There were opportunities for patients and those close to them to experience a range of environments. If patients wanted to get away from the hospital environment there was a woodland trail outside the hospital that was wheelchair friendly and provided views over the countryside. A senses garden included a fishpond with waterfall, plants of varying colour and scent and a terrace. Patients also had access to a holiday cottage in Selsey.
- The hospital had established "Special Interest Groups" covering a range of clinical areas such as infection prevention and control to ensure best practice and guidance was reviewed, considered, disseminated and managed throughout the hospital.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should expand information on duty of candour in the incident policy to indicate the practical application of candour as a point of reference for all staff
- The hospital should have a target in place for mandatory training completion
- The hospital should follow through the chain of disposal external to the hospital for assurance at least annually.
- The hospital should document its rolling schedule of planned preventative maintenance for equipment used to enable easy reference.
- The hospital should conduct additional resuscitation scenario training, this tests staff on their responses to an emergency.
- The hospital should establish key performance indicators within the pathology service level agreement setting out reporting.
- The hospital should review its arrangements for advanced care planning.

Outstanding practice and areas for improvement

- The hospital should review the use of syringe drivers to support patients on an end of life pathway and to provide medication where appropriate.
- The hospital should ensure all staff have an annual appraisal.
- The hospital should ensure all staff know how to access professional translation services.
- The hospital should devise a risk register that is prioritised and gives the management team assurance of safety across the organisation.