WM QRS West Midlands Quality Review Service

NHS

Quality Standards

Care of Adults with Acquired Brain Injury

These Quality Standards are beyond their review date

so should be used with caution as they may not be up to date

Version 1.2

July 2014

UKAS INSPECTION

Review by: July 2017 at the latest

Version No.	Date	Change from previous version
V1	09.07.2014	N/A
V1.1	09.02.2016	Paragraph added about organisation's clinical governance arrangements UKAS accreditation logo added
V1.2	27.09.2017	Text added to the front page - "These Quality Standards are beyond their review date so should be used with caution as they may not be up to date"

CONTENTS

INTRODUCTION

These Quality Standards were developed as part of the West Midlands Quality Review Service's 2013/14 work with NHS Herefordshire Clinical Commissioning Group and Wye Valley NHS Trust, in particular the Community Service for People with Acquired Brain Injury. Following consultation and comments from across the West Midlands they have been incorporated into the WMQRS suite of Quality Standards. In the future, WMQRS plans to incorporate the Quality Standards for the Care of Adults with Brain Injury into the WMQRS Standards for the Care of People with Long-Term Conditions.

Quality Standards aim to improve the quality of services for adults with acquired brain injury and help to answer the question: "For each service, how will I know that national guidance and evidence of best practice have been implemented?" The Quality Standards are suitable for use in self-assessment, monitoring by commissioners and providers, and peer review visits. They describe what services should be aiming to provide and all services should be working towards meeting all applicable Quality Standards within the next two to five years.

We hope that through the Quality Standards:

a. Adults with acquired brain injury, and their families and carers, will know more about the services they can expect.
b. Commissioners will be supported in assessing and meeting the needs of their population, improving health and reducing health inequalities, and will have better service specifications.
c. Service providers and commissioners will work together to improve service quality.
d. Service providers and commissioners will have external assurance of the quality of local services.
e. Reviewers will learn from taking part in review visits.
f. Good practice will be shared.
g. Service providers and commissioners will have better information to give to the Care Quality Commission and Monitor.

ACQUIRED BRAIN INJURY

Acquired brain injury includes:

a. Traumatic brain injuries such as open or closed head injuries
b. Non-traumatic brain injuries such as those caused by:
    i. strokes, tumours, infectious diseases (for example, encephalitis or meningitis),
    ii. hypoxic injuries (for example, asphyxiation, near drowning, anaesthetic incidents or severe blood loss),
    iii. metabolic disorders (for example, insulin shock or liver or kidney disease), and
    iv. toxic products taken into the body through inhalation or ingestion.

The term does not include brain injuries that are congenital or brain injuries induced by birth trauma.

(*NHS Scotland Traumatic Brain injury Knowledge Skills and Competencies 2011*)

SCOPE OF THE QUALITY STANDARDS

These Quality Standards are based on the definition above but exclude:

a. Acute care of people with trauma
b. Specific aspects of the care of people with acquired brain injury due to stroke (acute or post-acute), cancer or drug and alcohol use, although general rehabilitation of these patients is covered.
c. Care of children with acquired brain injury
d. Palliative and end of life care

The Quality Standards for the care of people with acquired brain injury do cover:

a. Post-acute care of people with traumatic brain injury, including the pathway for discharge from regional centres
b. Mental health care for people with Acquired Brain Injury
c. Care of adults with Acquired Brain Injury

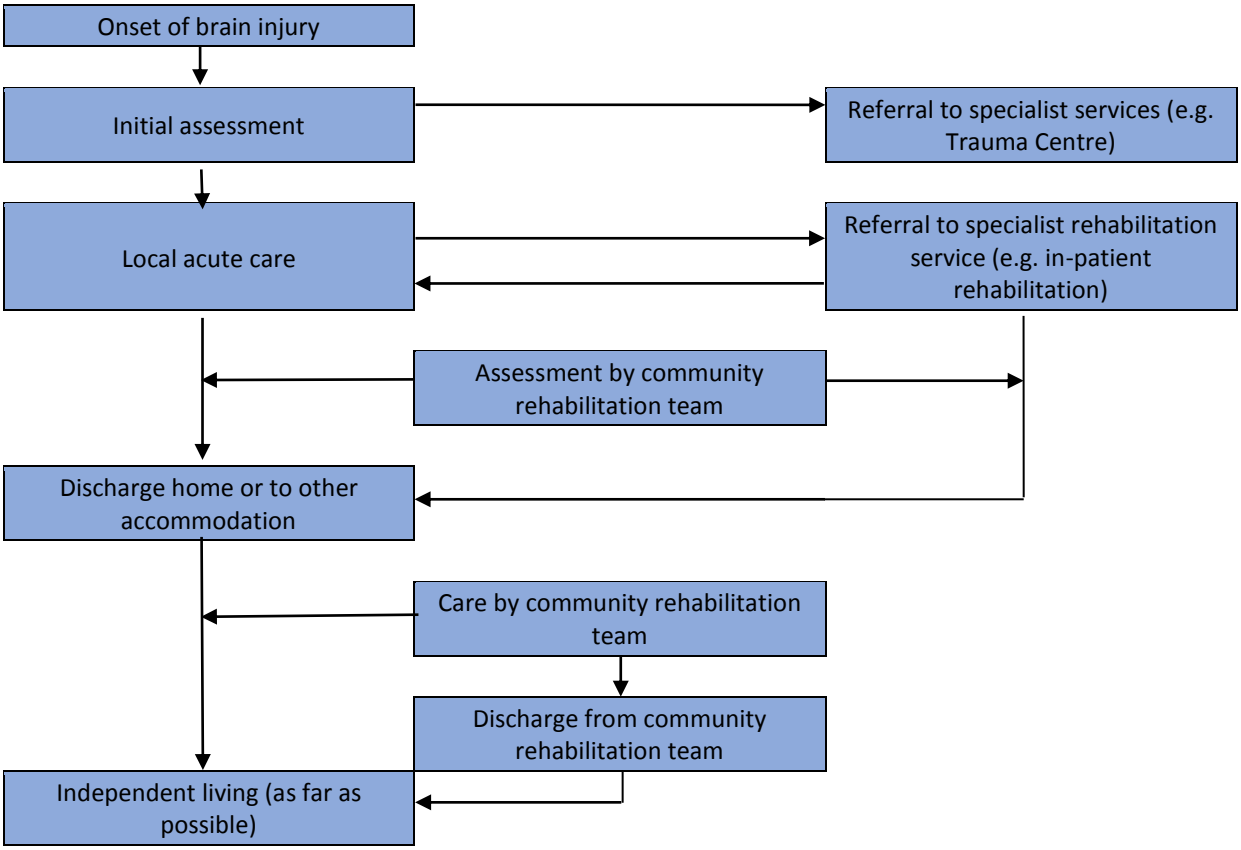
Transition to adult services normally takes place between the ages of 16 and 18. In exceptional circumstances transition may be delayed but should be completed by age 21. Flexibility in the age of transition may be necessary while commissioners and providers ensure appropriate arrangements are in place.

The Quality Standards are applicable to the care of adults with acquired brain injury in primary care, acute hospitals, and specialist assessment and rehabilitation services. They also cover the commissioning of services. The Standards cover all three levels of specialist rehabilitation services, although some standards are specifically applicable to in-patient care. The Quality Standards should also be seen alongside WMQRS Standards for the Care of People with Long-Term Conditions (available on the WMQRS website www.wmqrs.nhs.uk).

The Care of Adults with Acquired Brain Injury Quality Standards should sit within organisations' overall clinical governance arrangements. The WMQRS Clinical Governance Quality Standards describe the clinical governance arrangements which should be in place. Compliance in NHS provider organisations will usually be assured through NHS Litigation Authority Standards. Non-NHS organisations may wish to use the WMQRS Clinical Governance Quality Standards to assure themselves of the robustness of their overall clinical governance arrangements.

PATHWAY

The pathway of care for people with acquired brain injury is outlined below. This pathway will vary depending on the cause and severity of the brain injury[1]. It will also vary if the individual is detained under the Mental Health Act, under Deprivation of Liberty Safeguards, or under a Statutory Treatment Order or Community Treatment Order. Individuals' legal status may impact on potential locations of care.



[1] All patients with traumatic brain injuries should be considered as major trauma and transferred to a major trauma centre.

Linked Quality Standards

The Quality Standards for the Care of People with Acquired Brain Injury link with other WMQRS Quality Standards. Of particular relevance are the Quality Standards for:

a. Urgent Care – these incorporate acute care of adults with trauma
b. Mental Health Services
c. Care of Vulnerable Adults in Acute Hospitals

Latest versions of these Quality Standards are available on the WMQRS website www.wmqrs.nhs.uk

Structure of the Quality Standards

Each Standard is structured as follows:

<table>
<tr><td>Reference Number (Ref)</td><td>This column contains the reference number for each Standard which is unique to these standards and is used for all cross-referencing. Each reference number is composed of two letters (the first identifying the care pathway and the second the service to which a standard applies) and three digits (the first identifying the relevant section and the last two being unique to that Quality Standard).

The reference column also includes a guide to how the Standard will be reviewed:

<table>
<tr><td>BI</td><td>Background information for the review team</td></tr>
<tr><td>Visit</td><td>Visiting facilities</td></tr>
<tr><td>MP&S</td><td>Meeting patients, carers and staff</td></tr>
<tr><td>CNR</td><td>Case note review or clinical observation</td></tr>
<tr><td>Doc</td><td>Documentation should be available</td></tr>
</table>
The shaded area indicates the approach that will be used to reviewing the Quality Standard. Appendix 4 summarises the evidence needed for review visits.</td></tr>
<tr><td>Quality Standard (QS)

Notes</td><td>This describes the quality that services are expected to provide.
The notes give more detail about either the interpretation or the applicability of the Standard.</td></tr>
</table>

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

FA-	Acquired Brain Injury Pathway	Primary Care
FC-	Acquired Brain Injury Pathway	Acute Trust-Wide
FJ-	Acquired Brain Injury Pathway	Specialist Brain Injury Assessment and / or Rehabilitation Service
FZ-	Acquired Brain Injury Pathway	Commissioning

Topic Sections: Each section covers the following topics:

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

COMMENTS ON THE QUALITY STANDARDS

The Quality Standards will be revised as new national guidance becomes available and as a result of experience of their use in peer review. Comments on the Quality Standards are welcomed and will be taken into account when they are updated. Comments should be sent to swb-tr.SWBH-GM-WMQRS@nhs.net

More information about WMQRS and its Quality Standards and reviews is available at www.wmqrs.nhs.uk or 0121 507 2891.

QUALITY STANDARDS

PRIMARY CARE

Ref	Standard
FA-501 BI Visit MP&S CNR Doc	**Primary Care Guidelines** Guidelines on the primary care management of acquired brain injury should be in use, covering at least: a. Effects of brain injury, including physical, cognitive, emotional, behavioural, social, personal and practical problems b. Definition of brain injury and role of primary care in diagnosis, monitoring and management c. Criteria for referral to a specialist brain injury service and information to be sent with each referral d. Acute exacerbations and acute complications, including arrangements for rapid access to a specialist opinion e. Chronic complications f. Available regional and local brain injury services, support networks, outreach services, self-help groups and community services. *Note: Primary care guidelines should be consistent with the local pathway and guidelines in use in other local services.*

ACUTE HOSPITALS

Ref	Standard
FC-501 BI Visit MP&S CNR Doc	**Brain Injury Assessment and Management Guidelines** Guidelines on the assessment and management of patients with brain Injury should be in use, covering at least: a. Assessment of consciousness level (if there is any doubt whatsoever) by a team with specialist experience in profound brain injury b. Nutrition assessment and provision of additional nutrition (if required) within 48 hours of admission c. Establishing a moving and handling programme within 48 hours of admission d. Mood and cognitive screening within seven days of admission e. Referral for assessment and rehabilitation planning by a specialist neuro-rehabilitation service or local community rehabilitation service, depending on the severity of the brain injury. *Notes:* *1 Guidelines should be agreed with the specialist neuro-rehabilitation service and with local community rehabilitation service/s* *2 Referrals should be comply with commissioners' criteria for referral to each service.* *3 Provision of additional nutrition may be through a nasogastric tube, PEG, or parenteral feeding.*
FC-502 BI Visit MP&S CNR Doc	**Brain Injury Management Guidelines** Guidelines should be in use covering: a. Implementing agreed rehabilitation plan until the patient is medically fit for discharge b. Preventing secondary complications of brain injury (QS FJ-506)

Specialist Brain Injury Assessment and / or Rehabilitation Services

Ref	Standard
Information and Support for Patients and Carers	
FJ-102 BI Visit MP&S CNR Doc	**Service Information** Each service should offer patients and carers information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours (if applicable) *Note: Information may be combined with FJ-103.*
FJ-103 BI Visit MP&S CNR Doc	**Condition-Specific Information and Discussion** Patients and carers should be offered discussion and written information about their condition, covering at least: a. Description of their condition and its Implications b. Talking and physical contact with the patient, including the importance of regular breaks c. Likely problems and how to manage them, including the fact that problems sometimes only become apparent weeks or months later d. Information about regional and local brain injury services, support networks, self-help groups and other services available to provide support e. DVLA regulations and driving advice f. Venous thrombo-embolism prevention g. Falls prevention h. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, staying warm (vulnerable adults), mental and emotional health and well-being i. Information about legal assistance and possible sources of information concerning legal assistance j. Sources of further advice and information, including national and local voluntary organisations *Notes:* *1 Information may be in paper or electronic/e-learning formats, should be written in clear, plain English and should be available in formats and languages appropriate to the needs of the patients and their carers.* *2. Information may be provided at different stages of the patient pathway. Guidance on how to access information ('sign-posting') is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.*

Ref	Standard
FJ-104 BI Visit MP&S CNR Doc	**Rehabilitation Plan** Each patient and, where appropriate, their carer should discuss and agree their Rehabilitation Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-care and self-monitoring c. Name of 'care coordinator' d. Leisure and recreation activities e. Vocational / educational rehabilitation f. Other therapeutic and rehabilitation interventions g. Early warning signs of problems, including acute exacerbations, and what to do if these occur h. Planned review date and how to access a review more quickly, if necessary Where applicable: i. Nutrition, including food and drink textures j. Moving and handling programme for each patient with limited mobility k. Graded programme to increase tolerance to sitting / standing l. Plan for the management of contractures m. Bowel and toileting regime n. Communication and language interventions o. Cognitive, emotional and behavioural management interventions and support p. Interventions and support for mental health problems q. 'Looking to the Future' Plan The Rehabilitation Plan should be communicated to all staff within the service and copied to the patient's GP and other relevant healthcare professionals involved with their care. *Notes:* *1 The 'care coordinator' or 'key worker' should be the health or social care professional with lead responsibility for coordinating the patient's care. This individual may change over time as the patient's needs change.* *2 The plan for the management of contractures should include consideration of:* • *Elimination of simple causative/aggravating factors (pain, infection)* • *Specific treatment modalities such as splints or casts if appropriate* • *The use of antispasticity drugs including botulinum toxin where appropriate* • *Use of appropriate investigations for detection of heterotrophic ossification.* *3 The 'Looking to the Future' Plan may be called an advanced directive, Advanced Care Plan or, for some, an end of life care plan. This plan should include consideration of loss of independence and deterioration in the patient's condition as well as preparation for death.* *4 Care Plans should be easily accessible to patients and their carers. For inpatient services this would include a copy given to them or kept near their bed or chair but not Care Plans kept in trolleys or staff offices.*

Ref	Standard
FJ-105 BI Visit MP&S CNR Doc	**Review of Rehabilitation Plan** A formal review of the patient's Rehabilitation Plan should take place at least; • weekly (in-patient services) • three monthly (community services) • or, for patients in need of long-term and on-going support, at least annually. This review should involve the patient, their carer, the 'care coordinator' and other appropriate members of the multi-disciplinary team and any other individuals or organisations. The outcome of the review should be communicated in writing to the patient, their carer, their GP, staff within the service and other relevant healthcare professionals involved with their care, including relevant community rehabilitation services in the patient's local area.
FJ-106 BI Visit MP&S CNR Doc	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear. Response times should be not more than the end of the next working day. All contacts for advice and a sample of actual response time should be documented. *Note: The response by the end of the next working day means a response by, or following discussion with, a health or social care professional. It does not mean that a particular health or social care professional involved in the individual's care will respond by the end of the next working day.*
FJ-107 BI Visit MP&S CNR Doc	**Benefits Advice** Patients and carers should have easy access to benefits advice from an individual or organisation with specialist expertise in the needs of people with acquired brain injury.
FJ-108 BI Visit MP&S CNR Doc	**Discharge Information** Prior to discharge from the service, patients and carers should be offered discussion and written information covering, where applicable: a. Expected date of discharge from the service b. Plan of care and activities after discharge c. Medication d. Re-entry to the service, if required e. 'Short breaks' available and how to access these f. Other services available to provide support and care, support networks and self-help groups g. Adaptions available for the home h. Opportunities to learn skills, techniques and routines necessary to maintain rehabilitation gains i. Who to contact with queries or for advice *Note: Discharge may be the appropriate point on the patient pathway for discussion and information on aspects of QS FJ-103, or for re-emphasising some of this information.*

Ref	Standard
FJ-196 BI Visit MP&S CNR Doc	**General Support for Service Users and Carers** Patients and carers should have easy access to the following services. Information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. Independent advocacy services c. Complaints procedures d. Spiritual support e. *HealthWatch* or equivalent organisation *Notes:* *1 Information should be written in clear, plain English and should be available in formats and languages appropriate to the needs of the patients and their carers.* *2 This QS is about signposting to relevant services. The actual services available may be different in different areas.*
FJ-197 BI Visit MP&S CNR Doc	**Carers' Support** Carers should have discussion and written information about: a. What to do in an emergency b. How to access: i. An assessment of their own needs ii. Carer's breaks iii. Services which provide support for highly dependent people at home at short notice iv. Support for children in the family (if applicable) v. Counselling and cognitive and behavioural therapy *Note: Cognitive and behavioural therapy (CBT) may be provided through primary care-based psychological therapy services. Quality Standards for these services are included in the WMQRS Quality Standards for Mental Health Services. Carers should have long-term access to counselling and CBT.*
FJ-199 BI Visit MP&S CNR Doc	**Involving Users and Carers** The service should have: a. Mechanisms for receiving feedback from patients and carers about the care and treatment they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers *Note: The arrangements for receiving feedback from patients and carers may involve surveys, including the national patient survey, focus groups and/or other arrangements. They may involve Trust-wide arrangements so long as issues relating to the specific service can be identified.*
STAFFING	
FJ-201 BI Visit MP&S CNR Doc	**Lead Healthcare Professional** A nominated lead clinician should have responsibility for ensuring implementation of the Quality Standards for the service. The lead clinician should undertake regular clinical work within the service, should undertake Continuing Professional Development of relevance to this role and should have session/s identified for this role within their job plan.

Ref	Standard
FJ-202 BI Visit MP&S CNR Doc	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences, and cover for absences, should be available for the: a. Number of patients usually cared for by the service b. Service's role in the patient pathway c. Therapeutic and rehabilitation interventions offered The following specialist staff should have competences in caring for people with acquired brain injury and time for their work in the service identified in their job plan: i. Consultant in rehabilitation medicine ii. Other medical staff iii. Specialist nurse/s iv. Physiotherapist v. Occupational therapist vi. Psychological therapist vii. Dietician viii. Speech and language therapist ix. Social work x. Consultant psychiatrist and mental health nurse xi. Therapy assistant *Notes:* *1 A clear methodology should, ideally, be used to determine appropriate staffing levels and skill mix.* *2 The minimum sessional input from a consultant in rehabilitation medicine to a community service is one session every month.* *3 All specialist nurses should have completed an appropriate post-registration (LBR) education programme.* *4 Reviewers should be concerned about the availability of staff with appropriate competences rather than management arrangements. Staff may be covering other areas as well so long as there is sufficient time for their work with the service.*
FJ-214 BI Visit MP&S CNR Doc	**Competences – All Healthcare Professionals and Support Workers** All healthcare professionals and support workers working in the Unit should have competences appropriate to their role in: a. Adult safeguarding b. Recognising and meeting the needs of vulnerable adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Safe and appropriate moving and handling of patients f. Resuscitation
FJ-218 BI Visit MP&S CNR Doc	**Service Competences and Training Plan** The competences expected for each role providing care for people with acquired brain injury should be identified and the training and development plan for achieving and maintaining these competences described. *Note: Training may be delivered through a variety of mechanisms, including e-learning, Trust-wide training and departmental training.*

Ref	Standard
FJ-299 BI Visit MP&S CNR Doc	**Administrative and Clerical Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
SUPPORT SERVICES	
FJ-304 BI Visit MP&S CNR Doc	**Support Services** Timely access, including telephone advice and referral, to the following services should be available: a. Tissue viability specialists b. Epilepsy specialist nurse and consultant neurologist with particular interest in epilepsy c. Neurophysiology d. Continence advisors e. Chronic pain team f. Neurology g. Ophthalmology h. Employment and education services i. Pharmacy *Notes:* *1 'Timely' is not strictly defined but should ensure there are no unreasonable delays to the patient pathway or delays which may lead to deterioration of the patient's condition or quality of life.* *2 These services should usually be available within the local health economy.* *3 The consultant neurologist may also have a specialist interest in epilepsy.* *4 For community services, access to pharmacy advice may be through the patient's GP.*

Ref	Standard
FJ-305 BI Visit MP&S CNR Doc	**Specialist Services for People with Acquired Brain Injury** Timely access to telephone advice and referral for assessment and /or therapeutic intervention to the following specialist services should be available, a. Multi-disciplinary tracheostomy team b. Multi-disciplinary team with experience in the management of spasticity c. Neuropsychology and neuropsychiatry d. Neuro-endocrinology e. In-patient and day specialist acute brain injury rehabilitation providing physical, neurological and neuro-cognitive rehabilitation interventions f. In-patient mental health assessment g. Forensic mental health services, including for the care of sexual offenders h. Functional Electrical Stimulation i. Services for people with very complex disabilities including physical, cognitive and/or communicative deficits j. Specialist equipment including specialist wheelchair and seating systems k. Services providing electronic assistive technology or communication aids l. Services for people with significant and challenging behavioural problems m. Services for people with prolonged disorders of consciousness As part of the care pathway, specialist services should provide training and guidance for local teams involved in the care of patients with acquired brain injury. *Notes:* *1 'Timely' is not strictly defined but should ensure there are no unreasonable delays to the patient pathway or delays which may lead to deterioration of the patient's condition or quality of life.* *2 Parts of this QS will be not applicable if the service itself provides this aspect of specialist care.*
FACILITIES AND EQUIPMENT	
FJ-401 BI Visit MP&S CNR Doc	**Facilities** All services should have: a. Appropriate facilities for the assessment and management of patients with cognitive, behavioural, physical, psychological, communication and functional difficulties b. In-patient facilities only: i. Single rooms with sufficient space for use of hoists and equipment ii. Bathrooms and toilets with sufficient space for use of hoists and equipment iii. Appropriate hoists and equipment iv. Quiet areas v. Areas for families and carers, including access to refreshments *Note: Required facilities are not strictly defined but should be appropriate for the usual number and needs of patients cared for by the service.*

Ref	Standard
FJ-402 BI Visit MP&S CNR Doc	**Equipment** Timely access to equipment should be available, including at least: a. Resuscitation drugs and equipment, checked in accordance with local policy b. Pressure relieving mattresses and equipment c. Arrangements for calibration (if required), planned maintenance and emergency repair of all equipment used by the service d. A system for tracking, return and recycling of equipment (if appropriate) e. Store of appropriate equipment *Notes:* *1 Required equipment is not strictly defined but should be appropriate for the usual number and needs of patients cared for by the service.* *2 This QS covers equipment available locally. Access to specialist equipment is covered in QS FJ-304.*
GUIDELINES AND PROTOCOLS	
FJ-501 BI Visit MP&S CNR Doc	**Diagnosis Guidelines** Guidelines on the diagnosis of acquired brain injury should be in use. *Notes:* *1 This QS is applicable only to services involved in the diagnostic stage of the pathway.* *2 All guidelines should be based on national guidance, including NICE guidance and should be localised to show how national guidance will be implemented in the local situation.* *3 Information for patients and carers about the condition is covered in QS FJ-102.*
FJ-502 BI Visit MP&S CNR Doc	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use, covering at least: a. A full review of the patient's needs for rehabilitation and support b. Nutrition assessment and provision of additional nutrition (if required) c. Establishing a suitable moving and handling programme for each patient with limited mobility d. Assessment of mental capacity and Deprivation of Liberty Safeguards e. Discussion with the family or carers to establish their own needs and gain further insight into the needs of the patient within the home environment f. Feedback to the patient, their family or carers, their GP and to the referring clinician, summarising the results of the assessment and the recommendations made. In-patient services should complete nutrition assessment, provide nutrition via a nasogastric tube (if required) and establish a moving and handling programme within 48 hours of admission. *Notes:* *1 Information for patients and carers about the rehabilitation plan is covered in QS FJ-103-104* *2 For community services, initial assessment will have been undertaken earlier in the patient pathway and this QS will not be applicable.* *3 Provision of additional nutrition may be through a nasogastric tube, PEG, or parenteral feeding.*

Ref	Standard
FJ-503 BI Visit MP&S CNR Doc	**Monitoring and Management Guidelines** Guidelines on routine management should be in use covering, at least, the management of: a. Pain b. Spasticity c. Epileptic seizures d. Confused or agitated behaviour e. Fatigue f. Motor impairments and movement problems g. Bulbar problems affecting speech and swallowing (in-patient services only) h. Sensory dysfunction including hearing or visual loss i. Cognitive problems, especially mood, memory, concentration and orientation impairments j. Language and communication problems k. Bowel and bladder control problems l. Emotional, psychological and neuro-behavioural problems m. Mental health problems including anxiety, depression, suicidal and self-harming behaviour and psychoses n. Drug and alcohol problems o. Need for supportive seating and standing, aids and orthoses Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305). *Notes:* *1 As QS FJ-502 note 2.* *2 Guidelines should be agreed with relevant local services, including mental health and neurology services.* *3 Guidelines may be combined with other guidelines (QSs FJ-500s) or may be separate.*

Ref	Standard
FJ-504 BI Visit MP&S CNR Doc	**Full Assessment (when conscious)** Guidelines should be use which ensure that all patients, once conscious, are assessed by the multi-disciplinary team for common neurological impairments including: a. Pain b. Motor impairments and movement problems c. Bulbar problems affecting speech and swallowing (in-patient services only) d. Sensory dysfunction including hearing or visual loss e. Cognitive problems, especially mood, memory, concentration and orientation impairments f. Language and communication problems g. Control over bowels and bladder h. Emotional, psychological and neuro-behavioural problems i. Mental health problems including anxiety, depression, suicidal and self-harming behaviour and psychoses j. Functional ability, including Activities of Daily Living k. Assessment of participation, including social involvement l. Drug and alcohol problems m. Need for supportive seating and standing, aids and orthoses n. Family circumstances o. Impact on carers and children Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305). *Notes:* *1 As QS FJ-502 note 2.* *2 Guidelines may be combined with other guidelines (QSs FJ-500s) or may be separate.*
FJ-505 BI Visit MP&S CNR Doc	**Rehabilitation Planning** Guidelines on rehabilitation planning should be in use, covering at least: a. Patient and family involvement in agreeing the rehabilitation programme b. Rehabilitation interventions, their intensity, duration and goals (short and long-term) c. Multi-disciplinary involvement in rehabilitation interventions d. Recording of interventions and outcomes e. Arrangements for review of rehabilitation programme f. Actions to be taken when goals are not met *Notes:* *1 Recording of interventions and outcomes should be in a single patient record which links directly to the patient's Rehabilitation Plan.* *2 This QS is linked with QS FJ-104 Rehabilitation Plan.*

Ref	Standard
FJ-506 BI Visit MP&S CNR Doc	**Guidelines: Preventing Secondary Complications in severe Brain Injury** Guidelines on preventing secondary complications should be in use covering: a. Optimising respiratory function b. Tracheostomy management, including regular review, care and weaning c. Screening for and managing swallowing impairment, including instrumental diagnostic examination by video-fluoroscopy or Functional Electronic Stimulation d. 24 hour positioning and handling to avoid the development of contractures, pressure sores and aspiration into the lungs, and to allow satisfactory ventilation e. Regular inspection of skin areas at risk of pressure sores Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305). *Notes:* *1 As QS FJ-502 note 2.* *2 Guidelines may be combined with other guidelines (QSs FJ-500s) or may be separate.*
FJ-507 BI Visit MP&S CNR Doc	**Guidelines: Nutrition and Hydration in Severe Brain Injury** Guidelines on nutrition in severe brain injury should be in use, covering at least: a. Provision of nutrition via a nasogastric tube where patients are unable to maintain adequate nutrition orally b. At least weekly review of nutrition and hydration, including weighing the patient weekly c. Percutaneous endoscopic gastrostomy (PEG) feeding (or other appropriate stomal route) if the patient is unable to take adequate nutrition orally for more than two to three weeks after injury, unless contraindicated. d. Maintaining adequate nutrition and hydration during increased catabolism Guidelines should be clear about the indications for referral to other services (QSs FJ-304 and FJ-305). *Notes:* *1 As QS FJ-502 note 2.* *2 Guidelines may be combined with other guidelines (QSs FJ-500s) or may be separate.*
FJ-508 BI Visit MP&S CNR Doc	**Transfer Guidelines** Guidelines on care during transfer should be in use covering at least: a. Transfer between units b. Transfer to and return from local acute hospitals

Ref	Standard
FJ-598 BI Visit MP&S CNR Doc	**Transition** Guidelines should be in use covering transition from the care of local paediatric or CAMHS services including: a. Involvement of the young person and, where appropriate, their carer in the decision about transfer b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer *Notes:* *1 Transition guidelines should be agreed with local paediatric or CAMHS services.* *2 This QS is not applicable if the service does not care for young people transferred from paediatric or CAMHS services.*
FJ-599 BI Visit MP&S CNR Doc	**Care of Vulnerable Adults** Guidelines for the care of vulnerable adults should be in use, in particular: a. Restraint and sedation (QS MC-504) b. Missing patients (QS MC-505) c. Mental Capacity Act and the Deprivation of Liberty Safeguards (QS MC-594) d. Safeguarding (QS MC-596) e. Information Sharing Agreement (QS MC-597) f. Palliative care (QS MM-598) g. End of life care (QS MM-599) *Note: All 'MC' reference numbers refer to WMQRS Quality Standards for the Care of Vulnerable Adults in Acute Hospitals (V1). This is a linking QS and will not be separately reviewed. Any lack of compliance seen during review visits will, however, be noted.*

Ref	Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
FJ-601 BI Visit MP&S CNR Doc	**Operational Policy** The unit/service should have an operational policy covering at least: a. Criteria for referral to the service, including any exclusions b. Arrangements for dealing with urgent referrals c. Arrangements for initial and full assessment (QS FJ-502 and FJ-504) d. Arrangements for agreement and review of the Rehabilitation Plan (QS FJ-505) e. Allocation of the 'care coordinator' f. Arrangements for mental health input into the care of patients (QS FJ-602) g. Weekly multi-disciplinary meetings to review patients' rehabilitation goals and progress towards these, Rehabilitation Plans and discharge plans h. Input to reviews and discharge planning for local people with acquired brain injury who are being cared for outside the local area (community services only) i. Specialist in-patient services only: Communicating with community services and commissioners in the patient's local area about: i. Admission to the service ii. Outcome of assessments, rehabilitation plans, review dates and reviews of rehabilitation plan iii. Invitation to attend all review meetings j. Regular meetings with families k. Criteria for discharge from the service l. Arrangements for discharge (QS FJ-603 and FJ-604) m. Details of local and specialist services to which patients are usually referred (QS FJ-304 and FJ-305) and how to contact them *Note: Criteria for referral to and discharge from the service should be agreed by commissioners and should be consistent with those used by primary care (QS FA-501) and acute hospitals (QS FC-501).*
FJ-602 BI Visit MP&S CNR Doc	**Mental Health Input** Arrangements for input to the care of patients by mental health clinicians with an interest in the care of patients with acquired brain injury should be in place, including: a. Attendance at multi-disciplinary team meetings b. Input to the assessment and management of patients with acquired brain injury, including triage and referral to neuro-psychiatry c. Care of patients with pre-existing mental health problems d. Input to reviews of local people with acquired brain injury who are being cared for outside the local area e. Training and development of staff in the specialist brain injury rehabilitation service in the care of people with mental health problems f. Input to audit programmes *Note: Guidelines on the assessment and management of mental health problems in people with acquired brain injury are covered in QSs FJ-503 and FJ-504. Time for mental health staff is covered in QS FJ-202. This QS covers the agreed arrangements with mental health services for delivering this input.*

Ref	Standard
FJ-603 BI Visit MP&S CNR Doc	**Discharge Planning Protocol (In-patient services only)** A discharge planning protocol should be in use, covering at least: a. Identification of a lead member of the multi-disciplinary team who will coordinate the patient's discharge b. Risk assessment, including safety in the proposed environment and risk to others, particularly children. c. Assessment by a neurologist or a neurological rehabilitation specialist d. Need for continuing active rehabilitation and how this will be met e. Awareness of the person and their carers of the current problems and how to manage them f. Preparation of the patient and family g. Assessment of the discharge destination environment and support available h. Provision of any equipment and adaptations required i. Training of carers or family in the use of equipment and in managing the patient to ensure patient safety in the home environment j. Graded discharge, usually with short stay or weekend visits at home k. Handover to community teams, primary care teams and social services before discharge l. A written care plan copied to the patient, carer, the patient's GP and any services involved in their care and covering: i. All aspects of QS FJ-108 ii. Current needs iii. Planned care and handover to community rehabilitation services iv. Medication v. Standardised outcome measures at the time of discharge vi. Planned follow up (if applicable) vii. Contact for queries viii. Sources of continued information, support and advice m. Standardised outcome measure assessment, as a baseline for follow up (QS FJ-701) *Notes:* *1 This QS is not applicable to community-based services.* *2 QS FJ-601 covers communication with community-based services throughout a patient's in-patient stay. If the service complies with FJ-601, community services will be aware of discharge plans well in advance.* 3 *Any patient with acquired brain injury considered for discharge but who has not had an assessment by a member of the specialist neurological rehabilitation team should be notified to that team and should have an out-patient or fixed domiciliary visit appointment. A planned telephone contact within seven days may be sufficient if this is impractical and problems are judged to be minor.*
FJ-604 BI Visit MP&S CNR Doc	**Follow up and Evaluation of Longer-term Outcomes** Arrangements for follow up of each patient between 12 and 18 months after discharge, either by visit or phone, should be in place in order to assess: a. At least one standardised outcome measure b. Whether gains made during rehabilitation have been maintained c. Whether recommendations made at discharge were implemented, and whether there are other unmet needs *Note: This QS is applicable to community as well as in-patient services.*

Ref	Standard
FJ-605 BI Visit MP&S CNR Doc	**Annual Review Meetings** Meetings should be held at least annually to review liaison and address any problems identified with: a. Mental health services b. Benefits advice service c. Local acute hospital/s to which patients may be admitted
GOVERNANCE	
FJ-701 BI Visit MP&S CNR Doc	**Data Collection** There should be regular collection of data and monitoring of: a. Outcomes and goal attainment for the individual patient on agreement of the Rehabilitation Plan and at least three monthly thereafter b. In-patient services only: Completion of nutrition assessment, provision of nutrition via a nasogastric tube (if required) and establishing a moving and handling programme within 48 hours of admission.
FJ-702 BI Visit MP&S CNR Doc	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based guidelines (QS FJ-500s) b. Goal attainment and outcomes from patients' rehabilitation programmes *Note: Audit of goal attainment and outcomes will involve aggregation of individual patient data (QS FJ-701).*
FJ-798 BI Visit MP&S CNR Doc	**Multi-disciplinary Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from: a. Positive feedback, complaints, outcomes, incidents and 'near misses' b. Published scientific research and guidance
FJ-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines should comply with the document control procedures of the Trust or employing organisation.

COMMISSIONING

Ref	Standard
FZ-601 BI Visit MP&S CNR Doc	**Commissioning of Services for Adults with Acquired Brain Injury** The following services for people with acquired brain injury should be commissioned: a. Local community rehabilitation service/s b. Mental health input to the care of people with acquired brain injury (QS FJ-602) c. Input by community rehabilitation service/s and mental health service/s to input to reviews and discharge planning for local people with acquired brain injury who are being cared for outside the local area d. Access to specialist services for people with acquired brain injury (QS FJ-305) e. A range of living options including: i. Transitional accommodation for those with improving independence ii. Long-term supported living iii. Specialist long-term residential care, including for people with challenging behaviour or neuro-behavioural problems Criteria for referral to and discharge from each service should be specified. *Notes:* *1 'd' will involve coordination with Local Area Team commissioners of specialist services.* *2 'e' may be achieved by 'spot-purchasing' for individual patients.*
FZ-602 BI Visit MP&S CNR Doc	**Local Strategy and Coordination** The lead local commissioner should develop and agree a local strategy for people with acquired brain injury with: a. Patient and carer representatives b. Local services commissioned for people with acquired brain injury (QS FZ-601 'a' and 'b') c. Relevant local voluntary organisations d. Responsible senior social services manager e. Local acute hospital representative f. Primary care representative
FZ-701 BI Visit MP&S CNR Doc	**Quality Monitoring** The lead local commissioner should monitor aggregate data on goal attainment and outcomes from patients' rehabilitation programmes at least annually.

APPENDIX 1 REFERENCE SOURCES

Guidance Documents

1	2008	Health and Social Care Board	Brain Injury Service Standards and Quality Indicators
2	2008	Health and Social Care Board	Acquired Brain Injury Inpatient Care Pathway
3	2003	British Society of Rehabilitation Medicine and The Royal College of Physicians	Rehabilitation following Acquired Brain Injury
4	2007	National Institute of Clinical Excellence	CG56 Head Injury Guidelines, (partial update of CG4)
5	2013	Headway: The Brain Injury Association	Management of Acquired Brain Injury for GPs Factsheet, www.headway.org.uk
6	2013	Headway: The Brain Injury Association	Rehab and Continuing Care Factsheet, www.headway.org.uk
7	2013	Herefordshire Acquired Brain Injury Team	Standards: Assessments and Outcome Measurements adopted by the Herefordshire Acquired Brain Injury Team
8	2010	British Society of Rehabilitation Medicine	Specialist Neuro-rehabilitation Services Providing for Patients with Complex Rehabilitation Needs http://www.bsrm.co.uk/ClinicalGuidance/Levels_of_specialisation_in_rehabilitation_services5.pdf
9	2010	The British Psychological Society	Commissioning Clinical Neuropsychology Services - Division of Neuropsychology
10	2009	NHS Scotland	Acquired Brain Injury National Managed Clinical Network – Traumatic Brain Injury in Adults
11	2005	Department of Health	The National Service Framework for Long-term Conditions
12	2011	Royal College of Physicians and Association of British Neurologists	Local Adult Neurology Services For The Next Decade, Working party report

The table below shows the links between the Quality Standards for Care of People with Acquired Brain Injury and key guidance documents. Quality Standards without a reference source are based on the consensus view of the Steering Group which developed the Standards, taking into account comments received.

QS reference	Guidance documents	QS reference	Guidance documents	QS reference	Guidance documents
FA-501	1,4,5,11	FJ-214	3	FJ-598	1,11
FC-501	1,5,12	FJ-218	1	FJ-599	
FC-502	1,12	FJ-299		FJ-601	1,3,8,11
FJ-102	3,11	FJ-304	1,5,8	FJ-602	
FJ-103	1,3,4,11	FJ-305	3,8	FJ-603	1,2,7,11
FJ-104	1,3,11,12	FJ-401	1,11	FJ-604	7
FJ-105	1,10,11,12	FJ-402	1	FJ-605	
FJ-106	1,3,11,12	FJ-501		FJ-701	1,2,3,8
FJ-107	3,6	FJ-502	1,2,3,8	FJ-702	3
FJ-108	1,3	FJ-503	3,8,9,10,11	FJ-798	
FJ-196	3,6	FJ-504	3,8,9,10	FJ-799	

QS reference	Guidance documents	QS reference	Guidance documents	QS reference	Guidance documents
FJ-197	3,11	FJ-505	1,2,3,8,10,11	FZ-601	1,3,8,11,12
FJ-199	1,11	FJ-506	3,8	FZ-602	1,3,8,12
FJ-201	1,3	FJ-507	3,8	FZ-701	
FJ-202	1,5,8,9,12	FJ-508	1		

APPENDIX 2 CROSS-REFERENCES TO CARE QUALITY COMMISSION AND NHS LITIGATION AUTHORITY STANDARDS

Shaded boxes show where a WMQRS Quality Standard addresses one of the Care Quality Commission's *Essential Standards of Quality and Safety (2010)*. More detail can be found against each individual Quality Standard. The table also shows links between WMQRS Quality Standards and NHSLA Risk Management Standards.

	CQC Essential Standards of Quality and Safety														NHSLA Risk Management Standards 2013/14
	Respecting and involving people who use services	Care and welfare of people who use services	Meeting nutritional needs	Co-operating with other providers	Safeguarding	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, availability and suitability of equipment	Requirements relating to workers	Staffing	Supporting workers	Assessing and monitoring the quality of service provision	Records	
QS	1	4	5	6	7	8	9	10	11	12	13	14	16	21	
FA-501	■			■											2.8, 5.7
FC-501	■			■											2.8
FC-502	■			■											2.8
FJ-102	■														5.2
FJ-103	■														5.2
FJ-104	■	■												■	2.8, 5.2
FJ-105	■	■												■	2.8, 5.2
FJ-106	■			■											2.8, 5.2
FJ-107	■														5.2
FJ-108	■														5.2
FJ-196	■														2.3, 5.2
FJ-197	■														5.2
FJ-199	■												■		2.3, 5.2
FJ-201		■									■	■			1.9, 3.1, 3.2
FJ-202											■	■			1.9, 3.1, 3.2, 3.5, 3.7, 3.8
FJ-214												■			3.1, 3.2, 3.3, 3.4, 3.5, 3.7, 3.8
FJ-218												■			3.1, 3.2, 3.3, 3.4, 3.5, 3.7, 3.8
FJ-299											■	■			3.1, 3.2
FJ-304									■		■				2.8
FJ-305									■		■				2.8

		CQC Essential Standards of Quality and Safety												NHSLA Risk Management Standards 2013/14
	Respecting and involving people who use services	Care and welfare of people who use services	Meeting nutritional needs	Co-operating with other providers	Safeguarding	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, availability and suitability of equipment	Requirements relating to workers	Staffing	Supporting workers	Assessing and monitoring the quality of service provision	Records	
QS	1	4	5	6	7	8	9	10	11	12	13	14	16	21	
FJ-401									■						5.4, 5.5
FJ-402									■						5.4, 5.5
FJ-501	■	■											■		2.8, 5.7
FJ-502	■	■											■		2.8, 5.7
FJ-503	■	■											■		2.8
FJ-504	■	■											■		2.8
FJ-505	■	■											■		2.8
FJ-506	■	■											■		2.8
FJ-507	■	■											■		2.8
FJ-508	■	■											■		2.8, 4.9
FJ-598	■	■		■									■		2.8, 4.9
FJ-599				■	■								■		2.8
FJ-601	■	■		■							■				2.8, 4.9
FJ-602	■	■		■											2.8, 4.9
FJ-603	■	■											■		2.8, 4.9, 4.10
FJ-604	■	■											■		2.8, 4.9, 4.10
FJ-605		■		■											2.6
FJ-701				■									■	■	2.1
FJ-702				■									■	■	2.1
FJ-798		■		■									■	■	2.1, 2.2, 2.6
FJ-799				■									■	■	1.2
FZ-601	■	■											■		2.8
FZ-602	■	■											■		2.8
FZ-701		■		■									■	■	2.1, 2.2, 2.6

APPENDIX 3 GLOSSARY OF TERMS AND ABBREVIATIONS

Advocacy	Advocacy means to speak up for someone. It is about making things change because people's voices are heard and listened to. It's about making sure that people can make their own choices in life and have the chance to be as independent as they want to be.
ABI	Acquired Brain Injury
BI	Background information to review team
Carer	Throughout the Quality Standards the term 'carer' applies to both family carers and paid carers or support workers.
Commissioner	A commissioner decides how NHS and / or social care resources are spent, with the aim of improving health, reducing inequalities, and enhancing patient experience.
CNR	Case note review or clinical observation
CQC	The Care Quality Commission is the independent regulator of health and social care in England.
DH	Department of Health
Doc	Documentation should be available
GP	A GP is a medical doctor, sometimes called a family doctor. They are usually the first person patients see for their health care, and they help patients to access other services.
HealthWatch	The 'consumer champion' for both health and adult social care and should be the independent, influential and effective local voice of the public on health issues.
LBR	Learning beyond registration
Monitor	Monitor is the independent regulator of NHS Foundation Trusts.
MP&S	Meeting patients, carers and staff
MRI	Magnetic resonance imaging
NICE	National Institute for Health and Clinical Excellence.
PEG	Percutaneous endoscopic gastrostomy
Provider	A health or social care organisation which provides services to patients.
QS	Quality standard
Service provider	*See 'Provider'*.
Service commissioner	*See 'Commissioner'.*
Trust	A NHS Trust, NHS Foundation Trust or other organisation with management responsibility for the service.
WMQRS	West Midlands Quality Review Service

APPENDIX 4 PRESENTATION OF EVIDENCE FOR PEER REVIEW VISITS

Each Quality Standard reference column includes a box which illustrates how compliance will be reviewed.

Background information	This means that the information should be included in the background report or self assessment.
Visiting facilities	Reviewers will look for the information while they are visiting the service.
Meeting patients, carers and staff	These Standards will be discussed with patient, carers and /or staff as appropriate.
Case Note Review	A few Quality Standards require reviewers to look at case notes or other clinical information.
Documentation	These are policies, guidelines and other documentation which reviewers will need to see.

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	Visit	MP&S	CNR	DOC	
FA-501			X		X	**Guidelines:** Primary Care
FC-501			X		X	**Guidelines:** Brain Injury Assessment and Management
FC-502			X		X	**Guidelines:** Brain Injury Management
FJ-102		X	X		X	Information about the service
FJ-103		X	X			
FJ-104			X	X		
FJ-105			X	X		
FJ-106			X	X		
FJ-107		X	X			
FJ-108		X	X			
FJ-196		X	X			
FJ-197			X			
FJ-199			X		X	Examples of changes made as a result of feedback
FJ-201	X					
FJ-202	X		X		X	Examples of staff rotas
FJ-214			X		X	Examples of training records

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	Visit	MP&S	CNR	DOC	
FJ-218			X		X	**Competence Framework and Training Plan:** • Competence framework describing the competences expected for roles within the service. • Training and development plan to show how staff will achieve and maintain competences
FJ-299		X	X			
FJ-304	X		X			
FJ-305	X		X			
FJ-401		X	X			
FJ-402		X	X			
FJ-501			X	X	X	**Guidelines:** Diagnosis
FJ-502			X	X	X	**Guidelines:** Initial assessment
FJ-503			X	X	X	**Guidelines:** Monitoring and management
FJ-504			X	X	X	**Guidelines:** Full assessment (when conscious)
FJ-505			X	X	X	**Guidelines:** Rehabilitation planning
FJ-506			X	X	X	**Guidelines:** Preventing secondary complications in severe brain Injury
FJ-507			X	X	X	**Guidelines:** Nutrition and hydration in severe brain injury
FJ-508			X	X	X	**Guidelines:** Transfer
FJ-598			X		X	**Guidelines:** Transition
FJ-599			X		X	**Guidelines:** Care of Vulnerable Adults
FJ-601			X		X	**Policy:** Operational
FJ-602			X		X	**Arrangements**: Mental health input
FJ-603			X		X	**Protocol:** Discharge planning (in-patient services only)
FJ-604			X	X	X	**Arrangements:** Follow up and evaluation of longer-term outcomes
FJ-605			X		X	Minutes of meetings
FJ-701	X				X	Examples of data showing compliance
FJ-702					X	Audit programme or plan Examples of completed audits, action plans and monitoring.
FJ-798			X		X	Documentation depends on local arrangements, for example, minutes of review and learning meetings held within the service.
FJ-799					X	Compliance determined from other documentation presented.
FZ-601			X		X	Commissioning specification

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	Visit	MP&S	CNR	DOC	
FZ-602			X		X	Local Strategy
FZ-701			X		X	Examples of notes/ data showing compliance