York House Independent 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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We rated York House Independent Hospital as good overall because:

Following the last comprehensive inspection on 7 and 8 February 2017, we rated the hospital as good overall. We rated the service good for the effective, caring, responsive and well led domains and requires improvement for the safe domain. We issued a warning notice and a requirement notice under Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014. We told the hospital that staff must adhere to the hospital policy in relation to physical health monitoring following the administration of medication for rapid tranquillisation and ensure that all mandatory training meets the hospital compliance target. During this focused, follow up inspection, we found that the service had addressed the issues that had caused us to rate safe as requires improvement following the February 2017 inspection.

We rated the service requires improvement for safe because:

- There was no overall ward level ligature audit that identified all ligatures on the ward. This was not in accordance with National Patient Safety Agency guidance.
- Clinic rooms were too small to have examination couches and were cluttered. Medicines fridge temperatures were not always recorded daily in accordance with national guidance.
- There was limited multidisciplinary team support at weekends.
- Staff recorded incidents of harm as a result of patient assault, and prevention management of violence and aggression training was classified as desirable for nursing staff.
- York House hospital had not updated its local observation protocol to reflect the Disabilities Trust policy for corridor observations. This was identified at the last inspection. Staff were completing the observations but this did not reflect the local protocol.

However;

- Medicines management practice had improved. The provider had taken action to ensure that staff adhered to hospital policies in medicines management and staff acted in accordance with national guidance after they administered rapid tranquillisation to patients. The provider had introduced a prompt that explained rapid tranquilisation expectations and gave staff guidance on physical health checks and escalation. Risks associated with the administration of medicines for rapid tranquillisation were audited and reviewed.
- Mandatory training compliance for contracted staff had improved. First aid training was 5% below target however training was scheduled for November 2017. Wards identified staff with this training each shift and moved them to cover wards to ensure there was a suitable skill mix. Bank staff training was lower than the mandatory training compliance rates for eight courses but the service had implemented an online training platform to address this issue. Staff that did not have suitable training were not offered shifts on the wards.
- Staff now complied with infection prevention and control measures. The hospital's infection control lead completed infection prevention and control checks of staff and the environment.
- The reporting system that staff completed when incidents occurred now indicated the level of harm sustained because of the incident. The provider was also in the process of implementing a new electronic recording system that was to be fully rolled out by December 2017.

Summary of findings

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Good

York House Independent Hospital

Services we looked at
Services for people with acquired brain injury;

Summary of this inspection

Background to York House Independent Hospital

York House Independent Hospital forms part of the nationwide network of specialist rehabilitation centres provided by The Brain Injury Rehabilitation Trust (BIRT) which is in turn a division of The Disabilities Trust; a charity which provides services to people with physical disability, learning disability, autism and brain injury.

York House Independent Hospital is a 38 bed independent hospital, that provides an intensive neurobehavioural assessment and rehabilitation service. Patients have severe cognitive, physical, and/or emotional problems, following acquired brain injury.

The hospital had a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated regulations about how the service is managed. The hospital did not have an accountable officer in place at the time of inspection because they held an exemption certificate. An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

The hospital has three wards for patients with acquired brain injury;

- The Dales, a 14 bed male assessment and rehabilitation ward
- The Moors, a 14 bed assessment and rehabilitation ward for males and females, and
- The Wolds, a 10 bed long stay rehabilitation ward for males.

The service has been registered with the Care Quality Commission since 2 December 2010. It is currently registered to carry out four regulated activities, however the provider is in the process of removing accommodation for people who require nursing or personal care as a regulated activity as this does not reflect the service provided. The regulated activities are:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder, or injury, and
- accommodation for people who require nursing or personal care.

The hospital has been inspected by the Care Quality Commission on five previous occasions.

Following the last inspection on 7 and 8 February 2017, we rated the hospital as good overall. We rated the service good for the effective, caring, responsive and well led domains and requires improvement for the safe domain.

York House Independent Hospital has been subject to two Mental Health Act monitoring visits since our last comprehensive inspection.

- The Wolds on 17 June 2016, and
- The Moors on 8 December 2016.

We took the findings of the Mental Health Act monitoring visits, and actions the hospital said they had completed, into account during this inspection.

Our inspection team

Team leader: Clare Stewart, Inspector (Mental Health), Care Quality Commission

The team that inspected the service comprised of two Care Quality Commission inspectors and one member of the Care Quality Commission medicine management team.

Summary of this inspection

Why we carried out this inspection

We undertook this unannounced focussed follow up inspection to see whether York House Independent Hospital had made improvements to the service since our last comprehensive inspection in February 2017.

When we last inspected York House Independent Hospital the overall rating was good. However we found two Regulation 12 - Safe care and treatment breaches and rated the safe domain as requires improvement. As a result, we issued a warning notice and a requirement notice. We told the hospital it must take action to improve their services:

- Warning notice: Staff must adhere to the hospital policy in relation to physical health monitoring following the administration of medication for rapid tranquillisation.
- Requirement notice: The hospital must ensure that all mandatory training meets the hospital compliance target.

The provider sent us an action plan setting out the steps they were taking to meet the legal requirements of the regulation. The hospital should have met the requirements by June 2017.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection, we reviewed information that we held about York House Independent Hospital. This information suggested that the rating of good for effective, caring, responsive and well led at the comprehensive inspection in February 2017 were still valid. Therefore, during this inspection, we focused on the safe question. We did not review all of the recommendations we made following our February inspection. We will follow these up at the next comprehensive inspection and through engagement with the provider.

During the inspection visit, the inspection team:

- visited all three wards at the hospital and looked at the quality of the ward environment
- spoke with six patients and four relatives who were using the service;
- spoke with two senior staff nurses for two of the three wards;
- spoke with six other staff members; including the lead nurse, nurses, support workers and domestic staff;
- looked at nine risk assessments and care plans of patients;
- carried out a specific check of the medication management on all three wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that there were always enough staff on shift and that leave and activities were rarely cancelled or rearranged. Families and carers told us that staff seemed under a lot of pressure but that the ward staff were friendly and the hospital offered a good service.

All patients and carers told us that they felt safe on the wards. Five of the six patients told us that the wards were very clean, and two of four carers agreed; carers on the Dales described an odour on the ward.

Summary of this inspection

Patients told us that when they were restrained, they understood why and staff talked to them following incidents. Families told us that they received documentation relating to restraint and described the staff as very nice.

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?

Requires improvement 

We rated safe as requires improvement because:

- There was no overall ward level ligature audit that identified all ligatures on the ward.
- Clinic rooms were cluttered and were too small to have examination couches. Medicines fridge temperatures were not always recorded daily in accordance with national guidance.
- There was limited multidisciplinary team support at weekends.
- Staff recorded incidents of harm as a result of patient assault, and prevention management of violence and aggression training was classified as desirable for nursing staff.
- The Disabilities Trust policy acknowledged that there should be a member of staff present at all times at corridor locations but we did not see this reflected in the local protocol. This was identified at the last inspection.

However;

- The wards were clean, met same sex accommodation guidance and were well maintained. Staff monitored the appearance of the wards and each ward had an infection control champion. The infection control lead completed regular infection control audits.
- Medicines stored in clinic rooms and medicine refrigerators were stored securely with access restricted to authorised staff. There were adequate supplies of oxygen, defibrillators and medicines for use in a medical emergency available for each ward. Staff carried out regular checks to ensure these were available and fit for use.
- Nursing staff on the wards followed a shift pattern that allowed for the movement of staff between wards to cover increased levels of patient activity at peak periods during the day. Staffing shortages were covered by bank and agency staff that specialised in brain injuries and were familiar with patients and unit. Escorted leave and activities were rarely cancelled because of staffing shortages.
- Patients had comprehensive risk assessments that were regularly reviewed by the multidisciplinary team.
- The provider had introduced a prompt that explained rapid tranquilisation expectations and gave staff guidance on physical health checks and escalation. Risks associated with the administration of medicines for rapid tranquillisation and audited and reviewed.

Summary of this inspection

- Staff knew how to raise safeguarding concerns raised concerns via the provider's safeguarding form and the incident management system recorded level of harm. Staff and patients were debriefed following incidents and families and carers were kept updated.

Are services effective?

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Good

Are services caring?

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Good

Are services responsive?

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Good

Are services well-led?

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Good

Detailed findings from this inspection

Mental Health Act responsibilities

We did not review Mental Health Act responsibilities during this focused inspection. Since June 2016 all of the wards at York House Independent hospital had received a Mental Health Act monitoring review. There were no issued identified that related to the Safe question.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Mental Capacity Act and Deprivation of Liberty Safeguards responsibilities during this focused inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Following the last inspection on 7 and 8 February 2017, we rated the service good for the effective, caring, responsive and well led domains. Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect these key questions. During this focused, follow up inspection, we rated the service as requires improvement for the safe domain.

Good

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Requires improvement

Safe and clean environment

York House Independent Hospital has three wards across three floors. Lift access was available for patients with mobility issues. Access was via a secure reception area, where visitors and staff signed in and out.

Wards had blind spots and ligature points. Ligature points are places that patients could use to harm themselves by hanging or strangulation. Staff minimised the risk by increased patient observation levels. We requested an environmental ligature audit during the inspection but the hospital did not record ligatures in this format. The National Patient Safety Agency recommends that environmental risk assessments identify likely opportunities for hanging or other means of suicide. Instead of an environmental risk assessment that recognised ligatures, staff used a room environmental assessment tool to determine the suitability and risks posed in patients' bedrooms and shared areas such as corridors and lounges. Where ligature risks were identified staff completed a ligature action plan to mitigate the risk, however there was limited detail explaining how the risk was mitigated other than by increased observation levels. Staff confirmed that patients at risk of suicide would be placed in an appropriate room and would have an increased level of observation. The Dales had a safe room that was free from ligature risks and patients would stay in this room if at risk. The Moors and the Wolds also had a further two rooms each with anti-barricade doors that could be used by patients at risk of using ligature. Qualified nurses were able to adjust patient observation levels when required. Patients accessing the local community were usually escorted due to their injuries, so ligature risk was minimal and patients that were able to leave on their own were risk assessed prior to leaving the hospital.

The Moors was the only ward required to meet the Department of Health definition of same sex accommodation guidelines. This was because both male and female patients were admitted to the ward. Female patients had a dedicated female only corridor and all bedrooms had en-suite bathroom facilities. The female only lounge was off a shared corridor, however staff conducted observations and were present at all times. The Moors also had communal areas where male and female patients could socialise and take part in therapeutic activities together which is recognised as good practice on mixed wards.

All three wards had a clinical room where staff accessed medication and emergency equipment. Clinic rooms were too small to have examination couches and were cluttered. When a patient needed examination, these took place in patients' rooms. Three emergency grab bags were located between the three wards and all three wards had accessible ligature cutters. Clinic rooms had standard equipment available and where specialist equipment was required this was provided by the GP on weekly visits or patients were referred to a specialist. Equipment was clean and calibrated. We checked emergency equipment and found there were adequate supplies of oxygen, defibrillators and medicines for use in a medical emergency available for each ward. Staff carried out weekly checks to ensure these were available and fit for use. Check sheets were kept with each defibrillator and had a space for

staff to sign daily to confirm the defibrillator was in working order; however the policy said checks were to be completed weekly. These check sheets did not include a check of the expiry date of the defibrillator pads. In addition, checks had not been carried out between 20 August 2017 and 28 August 2017 on the Moors and between 16 August 2017 and 28 August 2017 on the Wolds.

We checked medicines stored in the clinic rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. Medicines fridge temperatures were not always recorded daily in accordance with national guidance and we found gaps in temperature records on all three wards. Staff took appropriate action when temperatures were recorded outside of the recommended range, however they did not always document their actions on the recording sheets. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were managed appropriately.

The wards were clean, had suitable furnishings and were well maintained. Staff monitored the conditions of the wards when completing the room environmental assessment tool for patients. At the last inspection we observed that some staff did not always adhere to the hospital infection prevention and control guidelines such as adequate handwashing, long hair not tied back, wearing nail varnish, and jewellery in excess of the policy guidelines. The organisation had resolved this issue. The hospital's infection control lead completed infection prevention and control checks of staff and the environment and handwashing posters were displayed by sinks. York House Independent Hospital set infection control as a mandatory course; 85% of contracted York House Independent Hospital staff and 86% of bank staff had completed this training. Housekeeping staff told us they had all the equipment they needed to keep the wards clean and they followed a schedule to clean the wards; there was a log of when each patients room had been cleaned by the bedroom door. Patients said that the wards were always clean and one patient described the cleaning schedule to us. Three of the four carers we spoke with felt the wards were clean. Two carers of patients on the Dales described an odour in the corridors; this was not obvious during the inspection. Each ward had an infection control champion and the infection control lead completed audits that fed into the quarterly governance report.

Staff had personal alarms whilst on duty and all three wards had an integrated alarm call system in the event of any emergency. Patients' rooms and communal areas had alarms so that they could summons assistance.

Safe staffing

The provider told us that they had no set establishment level but worked to 0.5 staff members per patient and one qualified nurse per ward. The provider also had additional staff to cover one to one observations. The establishment level is described by the National Institute for Health and Care Excellence as the number of registered nurses and healthcare assistant posts that are funded to work on wards to provide safe nursing care to each patient at all times.

Nursing staff on the wards followed a shift pattern that allowed for the movement of staff between wards to cover increased levels of patient activity at peak periods during the day. Staff worked the following shifts:

- Early - 07:00 to 14:20
- Late – 12:40 to 21:00
- Long Day – 07:00 to 21:00
- Night – 20:45 to 07:15

York House Independent Hospital had also created additional flexible shifts between 8am and 10pm to meet the needs of the patients on one to one observations. Senior staff nurses were on the rota, but not included in the establishment levels, to provide support across the wards, seven days a week. The provider also had a lead nurse available five days a week and a physical health nurse that focused solely on physical health monitoring three days a week that were not in the establishment numbers.

There were also psychologists, occupational therapists, social workers, physiotherapists, speech and language therapists, therapy assistants, psychology assistants and one psychiatrist across the wards to support patient; the psychology team also offered support to staff, for example, via debrief sessions following incidents. These additional staff did not work weekends unless they were on the on call senior management rota. During the inspection the number of nursing staff on shift matched those identified on the rota.

Good

Services for people with acquired brain injury

The total number of qualified nurse vacancies was eight however three nurses were recruited and were waiting to start their preceptorship with the organisation. The organisation used agency nurses to fill the vacancies. There were no support worker vacancies.

The hospital provided staffing data for us to review from the period of June to September 2017.

The number of shifts filled by bank staff and agency staff to cover sickness, absence, or vacancies was 701 of a possible 6359 shifts. Bank staff covered 177 shifts and agency staff covered 524 shifts.

A total of 103 shifts out of a required 6359 shifts were not filled by bank or agency staff to cover sickness, absence, or vacancies.

Staff said when they were short staffed; it was normally at the weekends. Weekend nursing staff numbers on the rotas were the same at weekends however there was not the same support from the additional multidisciplinary team. One staff member described phoning the provider's lead nurse who came in to help.

Staff sickness levels for York House Independent Hospital were 5% between October 2016 and September 2017.

Between October 2016 and September 2017, 101 staff had left the organisation. 20% of these staff had moved to bank work, and 27% of staff were bank staff that had no contract with the organisation. The hospital had recruited 90 staff during the same period; 77% of the staff recruited were rehabilitation support workers, 43% of which were bank staff.

The service was able to adjust staffing levels on the wards. The monitoring of staffing and rotas were coordinated by a centralised team who arranged for staff to move between wards; the same team also arranged bank and agency staff when necessary. The hospital used two recruitment agencies, one of which specialised in acquired brain injuries. Where possible the hospital used consistent agency staff that were familiar with the patients and wards. Agency staff received a ward induction and induction from the agencies that employed them.

There was always a qualified nurse available on each ward per shift, and nursing staff were present in the communal areas of the wards when patients used these areas. The service did not specifically allocate one to one time for patients with their named nurse however all patients we spoke with knew their rehabilitation support worker keyworkers and told us that staff had time to talk to them.

Patients told us that escorted leave and activities were rarely cancelled because of staffing shortages. On Dales, however, we were told that the ward was short staffed and activities were rearranged and leave was cancelled due to staffing levels as a result. Nursing staff said that when activities or leave was cancelled this was mainly due to ward activity and they were rearranged. The wards recorded cancellations on handover sheets so that the next shift could make appropriate arrangements. The occupational therapy team monitored when activities couldn't be provided to patients. Between June and September 2017 staff recorded the following hours of activities not going ahead as planned:

- Dales – 2.3 hours per patient over the 3 month period
- Moors – 3.3 hours per patient over the 3 month period
- Wolds – 2.6 hours per patient over the 3 month period

All patients and carers told us they felt safe on the wards and there was always enough staff to safely carry out physical interventions. When an incident occurred staff responded quickly.

The hospital had one 0.8 whole time equivalent consultant psychiatrist that covered the three wards during the day. An adjoining mental health hospital provided out of hours cover for the consultant psychiatrist when they were unavailable. Contact details for the out of hour arrangements were visible in duty offices and staff told us that doctors responded quickly in an emergency. York House Independent Hospital is a psychology led service which meant that in addition to the consultant psychiatrist there was also a 0.6 whole time equivalent consultant psychologist to support patients and staff.

At our last inspection we identified that two mandatory training courses were below the 75% target; these were emergency life support and immediate life support. This meant there might not have been enough suitably trained staff on duty and posed a potential risk to patient safety. We asked the provider to ensure that all mandatory training met the hospital compliance target. During this inspection, the hospital provided us with current training figures for bank and contracted staff. Both contracted and bank qualified nurses had exceeded the 75% training target

for immediate life support and were 88% and 75% respectively, however there was one instance where contracted staff did not meet this requirement and eight where bank staff fell below the training target.

- First Aid: Contracted Rehabilitation Support workers – 70%

Bank staff were mainly used to cover sickness absence and vacancies. For example between June and September 2017, bank staff covered 177 shifts of the 6359 shifts available. The provider told us that they expected bank staff to complete the same mandatory training as contracted staff.

York House Independent Hospital said that bank staff attending face to face courses was challenging because staff had other commitments outside of work. However where training was significantly overdue, shifts were not offered to those staff until they were fully compliant. The provider had recently implemented a new online training platform and had more success with the delivery of training in this format. They also told us that first aid training was lower because the provider had struggled to find an appropriate, suitable and new trainer, however this had been recently resolved and additional training was scheduled for November.

During the inspection we saw staff moving wards to make sure there were suitably trained staff working across the wards. Names of staff trained in immediate life support, first aid and prevention management of violence and aggression were clearly identified on the staff rotas and in the duty rooms.

Assessing and managing risk to patients and staff

York House Independent Hospital did not have a seclusion room and did not seclude or segregate patients. Staff and patients said that patients were always able to leave their rooms.

Episodes of restraint were recorded on a log in the duty office and sent to the management team for reporting purposes. There were 308 episodes of restraint recorded between March and September 2017; of these, 22 incidents were recorded as being restrained in the face down position and 18 of which related to one patient. All staff we spoke with could describe the reason for the use of prone restraint and we saw that staff moved the patient into supine as soon as practically possible. We saw quarterly governance reports reviewed these incidents; reoccurring prone interventions were risk assessed and identified as being the least restrictive option for the patient. Although breakaway and de-escalation training was mandatory for all staff, the prevention management of violence and aggression training was not because it was not applicable to all roles it was classed as desirable training. We saw that nursing staff trained in the prevention management of violence and aggression were identified on the rota and on staff boards in offices. The provider told us that 87% of contracted staff and 57% of bank staff had completed prevention management of violence and aggression training. They also told us that newly recruited bank staff were scheduled to complete this course as part of their induction, which will increase the bank staff training compliance to 71%.

We asked the provider for the number of incidents where staff had been assaulted by patients in the past six months and reviewed incident data from April to September 2017 provided by York House Independent Hospital. For this period the provider logged 15 staff injuries in an accident report however we identified 56 incidents from the incident log. The provider explained that information from the paper log was transcribed to two separate logs; one for audit purposes and another to record accidents and incidents. The provider told us that they are in the process of piloting an electronic recording system that will improve access to data.

We reviewed nine care records, three per ward. Every patient record contained a risk assessment on admission completed by the multidisciplinary team. When incidents occurred the patients' risks were evaluated, discussed and updated at the multidisciplinary team meetings. The patients' risk summaries were updated in their care plans and a copy of the meeting notes were stored in the patients' care plans to offer the rationale for the decision. Multidisciplinary team meetings occurred weekly and every patient was discussed on a four weekly rota or sooner as required. Where patients' risk was assessed as being an issue, the multidisciplinary team staff completed a separate care plan to manage the risk.

York House Independent Hospital used the Brain Injury Rehabilitation Trust risk matrix to assess risk as there is no other standardised measure for the patient population.

During the inspection there were no informally admitted patients on the wards but signs informing patients' of their

rights to leave were visible on two of the three wards. The Wolds did not have a sign but staff told us this would be displayed if a patient was informally admitted; there were patients on the Wolds that were restricted in their freedom under The Deprivation of Liberty Safeguards and detained under the Mental Health Act. Patients' rights were visible on information boards and in care plans; the provider had an easy read version of patients' rights to aid understanding. York House Independent Hospital had a locked doors policy detailing the rationale for this blanket restriction.

During the last inspection we identified that the York House local observation protocol did not refer to corridor observations. This meant that the protocol did not fully support staff who carried out observations on patients to keep them safe. While the Disabilities Trust policy identified that there should be a member of staff present at all times at corridor locations, we still did not see this updated in the York House protocol. Staff were visible and the observations were being carried out, however the local protocol had not been updated in line with the Disabilities Trust policy. The hospital supportive observation protocol identified how staff carried out different levels of observation depending on the patient's identified risks. Staff observed patients at greatest risk on level one which meant a designated staff member remained at arm's length from the patient at all times. Level two observations meant that a member of staff kept visual contact with the patient at all times and level three observation meant that delegated staff carried out intermittent observations at intervals such as 15 minutes or less. Level four observations meant delegated staff checked on patients assessed as low risk every hour. On occasions, some patients required more than one member of staff to observe them and sometimes staff observed patients differently at night.

The provider had a search policy in place and staff described one occasion where this had to be implemented following a risk to the patient. We reviewed the patient's care plan and incident form and saw that although the patient had been searched in line with the policy, the risk had passed to the patient and the search care plan needed to be updated.

Staff described de-escalation techniques and 85% of contracted staff and 82% of bank staff had completed breakaway and de-escalation training. Staff verbally de-escalated where possible and used distraction techniques. Staff explained that they knew the patients' preferences and gave examples of patients going for walks, having specific members of staff working with the patients or being taken to quiet areas.

We checked the arrangements for the safe management of medicines. We reviewed seven patient records in relation to medicines and spoke with nursing staff responsible for medicines.

At our last inspection in February 2017, we found the provider was failing to ensure that patients were protected against the risks associated with the administration of medicines for rapid tranquillisation. This was because nurses did not fully document physical health monitoring according to the hospital policy and current best practice guidelines. During this inspection we checked to see what improvements had been made. We reviewed seven episodes of rapid tranquilisation in detail, and found appropriate observations had been recorded in six cases. In one case, the patient's level of consciousness had not been recorded on the national early warning score chart when they had refused observations as set out in the provider's policy, however entries had been made in the patient's notes to indicate that they were alert.

The provider had introduced a prompt that explained rapid tranquilisation expectations and gave staff guidance on physical health checks and escalation. The provider told us that all staff, including agency, received training. Senior staff nurses completed a monthly audit of the rapid tranquilisation forms during the medicines audits, which were reviewed as part of the quarterly governance reports. The provider had not identified any issues but three members of staff said that if there was an issue this would be reviewed at supervision.

We reviewed medicines care plans for seven patients and found they did not contain sufficient detail in all cases. For example, one patient had a care plan for diabetes management and we found the dose of insulin did not reflect the amount they were prescribed despite a review taking place since the dose change; however we saw no impact as a result of this.

The hospital had policies and procedures in place to safeguard patients. Safeguarding adults and children training was mandatory for all contracted and bank staff. Both contracted and bank staff exceeded the 75% target for the safeguarding of vulnerable adults training course and

were 87% and 89% compliant respectively. Contracted staff had exceeded the 75% target for child protection training at 83% however only 65% of bank staff had completed this training.

Staff knew how to raise safeguarding concerns via the provider's safeguarding form. Managers reported all safeguarding notifications to the Care Quality Commission in a timely fashion. The hospital had a safeguarding policy and an identified safeguarding lead. All safeguardings were logged and reviewed by the safeguarding lead; these included whether a referral was accepted by the local authority. Where there was no external scrutiny the organisation held an internal investigation. The lead carried out safeguarding audits and was accessible to staff for support and advice. The safeguarding lead had a good relationship with the local safeguarding authority. Senior nurses attended additional safeguarding courses provided by the local authority.

Staff identified falls risks via the risk assessment process and completed care plans to manage the risks. One patient described the equipment they had to keep them safe from falls and told us that staff responded quickly. When patients were admitted with pressure sores, they managed them in line with guidance and reported them to the Care Quality Commission.

The wards did not allow children under the age of 16 to visit the wards; in the event that a child was to visit a patient, the wards would use a family room located at the adjoining hospital to ensure their safety.

Track record on safety

We asked the provider for details of serious incidents for the past 6 months. They reported that there had been none.

Reporting incidents and learning from when things go wrong

At the last inspection we identified that the incident reporting system that staff used did not indicate the level of harm sustained because of the incident. This meant it was not clear about the impact on patient safety when incidents occurred. We reviewed the provider's process and saw that level of harm was now included on the incident reporting form.

Staff knew what incidents were and reported them via paper forms that were kept in the duty rooms. Incidents were then transcribed and held centrally so that they could be reviewed. The Moors was piloting the introduction of an electronic incident reporting system, which included level of harm sustained, and the provider was planning on rolling this out for all wards by December.

We reviewed the incident log entries between April and September 2017. Staff recorded incident details such as incident type, form of aggression, triggers and details of any physical interventions. When patients were restrained, the timings and positions were recorded. One member of staff described a medicines error where they had involved the patient and advocate as well as recording the incident on the reporting system.

Two carers of patients described the review notes they'd received following an incident of restraint involving their family member and one patient described the discussion they had with staff following an incident. Patients also had regular community meetings where they could feedback.

Staff had debriefs following incidents although records were not kept of every discussion. One member of staff that had been harmed by a patient told us that they were supported following the incident and that debriefs were held by an appropriate staff member of the multidisciplinary team.

Staff had regular team meetings within their profession and newsletters were sent by the senior management team to further embed lessons learnt. We saw posters of lessons learnt meetings advertised to staff in staff only areas.

Duty of Candour

The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The organisation had a Duty of Candour policy that detailed the organisational approach. We saw that the Duty of Candour was part of the provider induction and was discussed at shift handovers. We asked the provider for details of any incidents that met the Duty of Candour threshold and they reported zero.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Services for people with acquired brain injury

Good

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Are services for people with acquired brain injury caring?

Good

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Are services for people with acquired brain injury responsive to people's needs?

(for example, to feedback?)

Good

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Are services for people with acquired brain injury well-led?

Good

Since the last comprehensive inspection in February 2017, we received no information that would cause us to re-inspect this key question.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff on each ward have access to an overall environmental ligature audit in line with best practice guidance.

Action the provider SHOULD take to improve

- The provider should review the system for recording medicines fridge temperatures and the action taken when temperatures fall outside of the recommended range.
- The provider should review medicines care plans to ensure they are accurate, up-to-date and contain the required information.
- The provider should consider reviewing the policy and checking procedure for emergency equipment to ensure that it is fit for use in the event of a medical emergency.
- The provider should consider making management of violence and aggression training mandatory for all staff.
- The provider should update its local protocol regarding corridor observations in line with the Disabilities Trust policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure that:** They did all that was reasonably practicable to mitigate any such risks. They did not follow good practice guidance to make sure risk was as low as is reasonably possible. **How the regulation was not being met:** The service did not have an overall comprehensive environmental ligature audit that detailed environmental risks to patients. This was a breach of 12(2)(b)