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 because:

- Staff protected patients from avoidable harm and abuse. Staff took a proactive approach to safeguard patients who were vulnerable and effectively managed risks on a daily basis. Staff ensured the environment was safe and clean and staffing levels were adequate to support patients safely.
- Staff planned patients' care and treatment in line with current evidence based guidelines and used outcome measures to monitor patients' progress. Staff considered the range and complexity of patients' needs and worked collaboratively with each other and other services to support patients' recovery. This included good access and outcomes in relation to physical health care. Staff were very mindful that they carried out least restrictive practice with their patients. They ensured they protected the rights of all patients concerning the Mental Health Act Code of Practice and the Mental Capacity Act and Deprivation of Liberty safeguards.
- The service demonstrated a very person-centred culture supported by organisational values and behaviours that kept patients at the heart of everything they did. Staff supported patients and their relatives with kindness, dignity, and respect. Staff sought feedback from patients and responded appropriately to meet their needs. The feedback we received from patients their relatives, and other people who used the service was overall positive.
- Staff ensured they met the needs of all patients who used the service. The facilities promoted comfort and confidentiality and included a range of suitable information to support their care and treatment. Staff used a range of communication methods to support patients to make choices about things that were important to them such as food and activities. Staff used the care programme approach to review patients' progress and plan discharge.
- All staff knew who the senior managers were by name. Managers were aware of the issues that were important to staff and morale amongst staff was generally good. The service had acted to make improvements since our previous inspection in February 2016. The service developed good systems to improve the quality of care and was committed to making continual improvements to the service.

However,

- Staff had not made all the improvements needed to ensure they followed the hospital policies and procedures following the administration of rapid tranquillisation. We had concerns about the impact on patient safety and issued the hospital with a warning notice.
- Not all staff had completed the required training for life support. The training compliance was below 75% overall which meant that there might not be sufficient, adequately trained staff on duty and patients could be put at risk.
- Staff adherence to some aspects of medicines management and infection prevention and control measures did not comply with the hospital policies and procedures.
- Staff did not do all they could to keep all information that related to patients confidential.
- Managers did not include bank staff in the supervision and appraisal arrangements for staff.
- Some patients had been at York House for many years because of difficulties finding appropriate placement to meet their complex needs. There was reduced staffing available at evenings and weekends to support patient activities. Some patients told us they felt bored at these times.

Summary of findings

- The hospital did not have a completed Workforce Race Equality Standard review to monitor and assure staff equality. The hospital observation protocol and the organisational smoking policy did not fully support staff and patients at York House.

Summary of findings

Contents

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 is a 38 bed independent hospital, which provides an intensive neurobehavioural assessment and rehabilitation service. This is for people with 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;

Dales – 14 beds assessment and rehabilitation for males with an acquired brain injury.

Moors –14 beds assessment and rehabilitation for males and females with acquired brain injury.

Wolds- 10 beds long stay rehabilitation for males with an acquired brain injury.

York House has been registered with the Care Quality Commission since 2 December 2010. It is registered to carry out four regulated activities;

(1) accommodation for people who require nursing or personal care,

(2) assessment or medical treatment for persons detained under the Mental Health Act 1983,

(3) diagnostic and screening procedures,

(4) treatment of disease, disorder, or injury.

The hospital has been inspected by the Care Quality Commission on four previous occasions. Following the last inspection on 15 February 2016, we rated the hospital as requires improvement. This was because we rated the service as requires improvement for the safe, effective, responsive, and well–led domains and good for caring.

Following our inspection in February 2016 the service told us about the action they took to make the improvements. The service told us that they completed all these actions by January 2017.

We carried out this comprehensive inspection in February 2017 and found that the hospital had taken action to make the required improvements.

York House has been subject to two Mental Health Act monitoring visits since our comprehensive inspection in February 2016. The first visit took place on 17 June 2016 on The Wolds and The Moors was subject to a Mental Health Act monitoring visit 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: Jacqueline Bond, Inspector (mental health hospitals) Care Quality Commission

The team that inspected the service comprised two Care Quality Commission inspectors and one member of the medicines management team, and a variety of specialists: one expert by experience, one speech and language therapist, one nurse, one occupational therapist and one consultant psychiatrist.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

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 visit, we reviewed information that we held about the service and sought feedback from 67 staff at thirteen focus groups.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 10 patients and four relatives who were using the service;
- spoke with the registered manager and senior staff of the service;
- spoke with 23 other staff members; including the doctor, nurses and support workers, occupational therapists, psychologists, speech and language therapists, physiotherapy staff and social worker;
- received feedback about the service from the local GP practice and the local authority;
- spoke with an independent advocate;
- attended and observed three hand-over meetings and three multi-disciplinary meetings;
- collected feedback from one patient using comment cards;
- Looked at 16 care and treatment records 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 provided feedback on the service they received before our inspection via comments boxes and cards left on all three wards and the main reception area. We received one completed comment from a patient on The Dales, which made positive comments about how the service was well staffed and organised.

Ten patients told us about the care and treatment they received. Overall, patients spoke positively about the staff and their experience. Patients were happy and said they felt safe, with enough staff available to support them with their needs. Patients felt staff involved them in their care and supported them to make choices in their care such as activities. Patients commented that staff were caring, polite, and efficient. Two negative comments related to patients feeling bored with not enough activity to keep them occupied and that some staff were better than others.

We spoke with four relatives over the telephone who made positive comments about the care and treatment of their relative at York House. All relatives felt that York House was a clean and comfortable environment and they felt confident about the care and treatment their relative received. Relatives said staff were kind and welcoming. In their experience, there was always enough staff available. Relatives felt staff kept them informed and involved in their relatives care and felt that staff listened to them and responded to any concerns.

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;

- Staff did not always act in accordance with national guidance after they administered rapid tranquillisation to patients. It was unclear on medicine prescription charts who had prescribed some medications, which was not in keeping with the hospital medicines policy. There was no record of medicines reconciliation in the patient's notes. This meant there was no way of evidencing medicines reconciliation had occurred.
- Mandatory training was below 75% for emergency life support and immediate life support. This meant there might not be enough suitably trained staff on duty and posed a potential risk to patient safety.
- We observed that staff did not always comply with infection prevention and control measures such as washing their hands thoroughly when they carried out clinical care. This meant there was a risk that patients and staff could be exposed to infection.
- The reporting system that staff completed when incidents occurred 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.

However,

- Staff maintained a local risk register and carried out appropriate environmental and individual risk assessments to keep patients safe. Patients and staff had access to working alarms and a call system. All three wards were visibly clean and well maintained. Staff carried out regular checks to ensure the buildings, environment and equipment were clean and safe for patients and staff.
- One of the three wards provided accommodation for both male and female patients. This ward provided an environment that met the current national guidelines for good practice on mixed sex wards.
- Clinical rooms were clean and well organised. Staff did regular checks to ensure that all medicines and emergency equipment was safe to use.

Summary of this inspection

- Maintaining safe staffing levels was a daily challenge; however, managers took action to ensure wards were adequately staffed. The hospital had an active recruitment plan for vacant posts and mitigated the impact with the use of regular bank and agency staff wherever possible. All patients had scheduled activity and therapy time that was rarely cancelled due to staff shortages.
- Staff used the principles of least restrictive practice and positive and pro-active care. Staff did not use seclusion or long-term segregation with patients. Staff used de-escalation as their first intervention and restraint as a last resort to keep patients safe. All staff received training that supported them to keep patients and themselves safe. Staff understood their responsibilities to safeguard patients and hospital policies and procedures supported staff to protect patients' from avoidable harm.
- Staff reported all incidents or risks of harm and the hospital notified the Care Quality Commission of incidents in a timely way. The hospital had a policy about their responsibilities under Duty of Candour and staff were open and honest with patients and carers. The hospital used a range of communication methods to share information about incidents so that staff could learn lessons and make improvements. This included bespoke tutorials and de-briefs.

Are services effective?

Good

We rated effective as good because;

- All records were accessible to staff when needed and stored securely. Staff kept individualised records that focused on patients' recovery. Patients received comprehensive multi-disciplinary assessments and treatment supported by best practice guidance.
- Staff ensured patients had access to physical health care and a range of other specialist health services when patients needed them. This was good practice and in keeping with the Mental Health Act Code of Practice 2015.
- There was a range of staff who were suitably qualified to provide a full multi-disciplinary approach to patient's care. Induction for new staff, training, supervision and appraisal arrangements meant that staff received the training and support they needed for their roles. Staff had good working relationships with other agencies that supported effective communication about patient care and treatment.

Summary of this inspection

- Staff training in the Mental Health Act and Mental Capacity Act was mandatory and compliance reached over 75%. Staff carried out capacity assessments and best interest meetings and supported interventions with patients who lacked capacity with detailed care plans. The hospital had good arrangements that ensured staff protected patient's rights in accordance with the Mental Health Act and Mental Capacity and Deprivation of Liberty Safeguards. This included training and up to date policies. This was important because most patients at York House were detained under the Mental Health Act or Deprivation of Liberty Safeguards. The hospital had good relationships with the independent advocate and ensured all patients had access to this service. Staff had acted to resolve all issues from previous Mental Health Act monitoring visits since our last inspection in February 2016.

However,

- Others could view visual boards that displayed patient information in staff duty rooms through a window in the door. This meant there was a risk of confidential information being seen by people not directly involved in patient's care.
- York House did not include bank staff in their supervision and appraisal arrangements. This meant that despite the regular use of bank staff to maintain staffing levels, their performance was not monitored in the same way as employed staff.
- The effectiveness of meetings, including multi-disciplinary meetings and nurse handovers was affected by communication difficulties and inconsistencies in the information that staff shared.

Are services caring?

Good

We rated caring as good because;

- We observed many kind, intuitive and caring interactions between staff and patients. Staff knew individual patients very well and used detailed and person-centred care plans to effectively understand, anticipate, and meet patients' needs. Staff supported patients in a compassionate, kind and timely way and treated patients with dignity and respect. Staff ensured that all patients were included in decisions about their care and treatment. Staff made great efforts to support patients to learn new skills and develop independence. Staff felt very satisfied that they could help support patients achieve their goals and expectations. The feedback we received was very positive and patients and their relatives told us staff treated patients in a very kind and caring manner.

Summary of this inspection

- Staff involved patients and their families as partners in their care, treatment, and rehabilitation. Staff encouraged patients and their relatives to take part in meetings about their care and treatment wherever possible. Staff supported patients to make informed decisions and minimised any barriers to communication with the use of appropriate communication aids and methods.

Are services responsive?

Good

We rated responsive as good because,

- Staff assessed patients referred to the hospital in a timely manner. There was no waiting list for patients waiting for assessment. Staff declined referrals to the hospital when their assessment indicated they could not meet the individual patients' needs. When this happened, staff made alternative recommendations to the referrer. The bed occupancy levels were low on The Dales in recognition of the complex needs of the patients and the need for safe staffing levels.
- The wards had clear pathways for patients care and treatment depending on their needs. All three wards were recovery focused and staff prepared patients for their discharge in a structured way. Any delays patients experienced with their discharge were not because of clinical issues at the hospital.
- The environment at York House promoted patients' recovery, comfort, dignity, and confidentiality. Since our last inspection in February 2016 environmental improvements meant there was full range of rooms available to support patients' care and treatment. This included designated private rooms for confidential discussions to take place with patients.
- York House ensured they met the needs of all patients who used the service. The building was fully accessible for people who required assistance. Staff supported patients who required specific help with communication, religious or cultural needs and ensured patients had access to everything they needed.

However,

- Some patients at York House had been there for many years and staff told us there were difficulties finding appropriate placement to meet their complex needs.
- Some patients chose not to have privacy screening on the windows that looked out into the hospital grounds. We were concerned that people in the hospital grounds could potentially see through the windows, which could compromise patients' dignity and privacy.

Summary of this inspection

- Clinical and therapy staff in addition to ward-based staff provided a wide range of activities and therapies for patients during the week. However, clinical staff and therapy staff did not work at evenings or weekends, which meant that only ward staff were available to support activities. Patients told us they felt bored and staff told us it was more difficult to support patient activities during the evening and at weekends.

Are services well-led?

Good

We rated well-led as good because;

- Managers at York House were visible and accessible to all staff. Staff knew who the senior managers were at the hospital and identified them by name. Staff felt confident to speak up to senior managers if they had concerns and managers knew about the issues that staff were worried about. Managers took a range of actions to ensure there was always sufficient and adequately trained staff to keep patients and staff safe.The ongoing recruitment of staff mitigated the risks associated with the high use of bank and agency staff.
- Morale amongst staff had improved and managers consulted with staff about decisions that affected the service.
- Managers took action to ensure the service made all the required improvements from our inspection in February 2016 and Mental Health Act monitoring visits. Systems and processes ensured that all policies were up to date and mandatory training and appraisal compliance had improved.
- Staff and managers were very proud of their service. They monitored the quality of the care they provided and were committed to make further improvements. Staff completed a range of detailed audits and actions and routinely measured patient outcomes. The leadership and culture within the service promoted the delivery of high quality, person-centred care. All the feedback we received was overall very positive about the care and treatment staff provided to patients and relatives at York House.

However,

- The hospital did not have a completed Workforce Race Equality Standard review. This meant that managers could not monitor and assure staff equality and did not comply with the requirements for the Workforce Race Equality Standards.

Summary of this inspection

- The hospital did not have a policy that demonstrated how staff supported inpatients who smoked. The 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.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We took into account the two Mental Health Act monitoring visits carried out since our comprehensive inspection in February 2016. The Wolds was subject to a Mental Health Act monitoring visit on 17 June 2016.The visit raised one issue about lack of clear records about discharge planning and discharge care plans for patients. The Moors was subject to a Mental Health Act monitoring visit on 8 December 2016 and found one issue about lack of evidence of care plan reviews in two records, and one record where medical staff had not recorded that they considered a community treatment order when patients had over seven days section 17 leave. At this inspection, we found that staff had completed work to resolve all the issues from the two Mental Health Act monitoring visits.

At our comprehensive inspection in February 2016, we found the hospital did not have a locked door policy. At our inspection in February 2017, the hospital had updated their policies in relation to the current Mental Health Act Code of Practice and included a locked door policy.

A Mental Health Act lead and administrator based at York House oversaw all matters that related to the Mental Health Act. They provided training and advice and monitored staff adherence to the Mental Health Act Code of Practice. All staff at York House had received mandatory training in the Mental Health Act. This was above the 85% compliance target. Staff were aware of the hospital policies and had a good understanding of the Code of Practice. They knew who to go to for further advice or information if required and spoke very highly of the timely and knowledgeable support they received.

Staff took action to protect patients' rights under the Mental Health Act, which included access to independent mental health advocates.

Mental Capacity Act and Deprivation of Liberty Safeguards

York House provided mandatory Mental Capacity Act training and reported that 87% of staff had received this training. This was above the hospital target of 85%.

The hospital reported 14 applications for the Deprivation of Liberty Safeguards between 1 May 2016 and 31 October 2016. The Wolds and The Moors reported six applications each and The Dales reported two applications during this period. Four patients were awaiting renewal of the standard Deprivation of Liberty Safeguards application and one urgent application.

At our previous inspection in February 2016, we found that the Mental Capacity Act policy was out of date, however York House now had an up to date policy that was available for staff.

The Mental Health Act lead and administrator also acted as a lead for Mental Capacity Act and Deprivation of Liberty Safeguards. They oversaw all matters that related to the Mental Capacity Act and Deprivation of Liberty Safeguards. They provided training and advice and monitored staff adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff at York House had received mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was above the 85% compliance target. Staff were aware of the hospital policies and had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. They knew who to go to for further advice or information if required and highly valued the timeliness and quality of support they received. This was important because there were patients on the wards who had an authorisation that deprived them of their liberty. This legal framework safeguards the human rights of people who lack capacity to make decisions about their admission to hospital and are under continuous care and supervision. Staff made applications to the local authority for new assessments in a timely manner and maintained contact with the local authority to check the progress of their applications.

Detailed findings from this 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

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

Staff at York House took a range of actions to ensure the environment was safe and clean for patients and visitors.

People accessed York House through a secure reception area, where all visitors and staff were required to sign in and out. Each ward identified a member of staff responsible for security on a daily basis. This included checking alarms and keys.

At our inspection in February 2016, we found that the hospital did not have cleaning schedules that were completed, monitored, and audited to ensure the cleanliness of premises. At this inspection in February 2017, we reviewed the health and safety, maintenance and cleaning records for the hospital and found staff kept up to date records. All wards were clean and well maintained. Maintenance and cleaning staff dealt with any issues in timely manner during our inspection. During the inspection, maintenance staff carried out work on door handles and cleaning staff attended to cleaning in one room that had an unpleasant aroma. People who visited the hospital regularly told us that the hospital was clean.

All three wards had completed environmental risks assessments that identified dangers including ligature points. Ligature points are places that patients could use to harm themselves by hanging or strangulation. Staff carried out regular checks on the environment to monitor and mitigate the identified risks in addition to individual patient observations. Staff had access to personal alarms whilst on duty and all three wards had an integrated alarm call system in the event of any emergency.

When patients were referred to York House, staff carried out assessments of patients' risk of self-harm, and suicide. Staff considered if identified risks could be managed safely before agreeing to an admission. All patients at York House had up to date individual risk assessments and staff carried out observations to keep patients safe. We observed staff were always present in communal areas and they carried out patients' individual observations according to the hospital protocol. This included corridor observations for one patient. Corridor observations meant that a member of staff must be in place on the main corridor of the ward at all times. The hospital observation protocol did not provide information about corridor observations however, the individual care plan and risk assessment made this clear for staff. All staff and patients we spoke with told us they felt safe on the wards.

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. The layout on the Moors meant that female patients had a dedicated female only corridor with bedrooms that had en-suite facilities and a separate dedicated female only lounge area. This is good practice and meets the requirements of current national guidelines. This was in addition to communal areas where male and female patients could socialise and take part in therapeutic activities together. This is also recognised as good practice on mixed wards.

Good

Services for people with acquired brain injury

All three wards had a clinical room where staff accessed medication and emergency equipment. Three emergency grab bags were located between the three wards and all three wards had accessible ligature cutters.

We checked the clinical rooms on each ward. None of the rooms were large enough to contain an examination couch for patients to use when doctors carried out physical examinations. However, the hospital had one room that contained an examination couch. This was used by physiotherapy staff with patients, and was available for physical examinations. Patients also had physical examinations on their beds in their rooms. Staff kept clinical rooms clean and tidy and regularly checked resuscitation equipment kept in the clinical room. At our previous inspection in February 2016, we said the hospital should ensure that room temperatures were monitored and maintained at the required temperature and that that medicines requiring refrigeration were stored in accordance with national guidance. At this inspection, we saw that staff checked the room and medication fridge temperatures daily and took action where required. All temperatures were within the required range when we visited.

York House did not have a seclusion room. The Dales had a safe room that was free from ligature risks and identified as a place for patients to use as a short-term measure to manage risks. The room had a clear viewing panel and contained sleeping, washing and toilet facilities and a visible clock. Staff did not restrict patients' movements and patients were free to leave the room at any time. Staff understood the definition of seclusion according to the Mental Health Act and we felt assured that patients were not secluded.

Staff on all three wards had access to hand washing facilities and disinfecting hand gels for infection control. The hospital had an identified infection control champion who completed regular infection control audits. However, 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.

Safe staffing

The hospital reported the total establishment levels for each ward between 7 August 2016 and 30 October 2016. We checked on the accuracy of these figures with the hospital after the inspection because the figures could be interpreted as meaning there were no qualified nurses on two of the wards. We knew this could not be the case because the duty rotas showed evidence that all three wards had at least one qualified nurse on duty on every shift. We also spoke with qualified nurses during our inspection who worked on all three wards.

The hospital provided us with the revised figures;

The Dales;

Total establishment levels were 8.0 qualified nurses and 19 nursing assistants (whole time equivalent).

Total number of qualified nurse vacancies was four with no nursing assistant vacancies (whole time equivalent). The ward had eight rehabilitation support workers above the establishment levels.

The number of shifts filled by bank staff and agency staff to cover sickness, absence, or vacancies was 707. (Bank staff covered 216 and agency staff covered 491 shifts).

A total of seven shifts out of a required 2110 shifts were not filled by bank or agency staff to cover sickness, absence, or vacancies.

The Moors;

Total establishment levels were 8.0 qualified nurses and 18 nursing assistants (whole time equivalent).

Total number of qualified nurse vacancies was 0.81 with no nursing assistant vacancies (whole time equivalent). The ward had seven rehabilitation support workers above the establishment levels.

The number of shifts filled by bank staff and agency staff to cover sickness, absence, or vacancies was 1043. (Bank staff covered 463 and agency staff covered 580 shifts).

A total of 92 shifts out of a required 2619 shifts were not filled by bank or agency staff to cover sickness, absence, or vacancies.

The Wolds;

Total establishment levels were 5.2 qualified nurses and 15 nursing assistants (whole time equivalent).

Total number of qualified nurse vacancies was 2.87 with no nursing assistant vacancies (whole time equivalent).

Good

Services for people with acquired brain injury

The number of shifts filled by bank staff and agency staff to cover sickness, absence, or vacancies. was 464. (Bank staff covered 176 and agency staff covered 288 shifts).

A total of 46 shifts out of a required 1452 shifts were not filled by bank or agency staff to cover sickness, absence, or vacancies.

York House reported on the total sickness, vacancies, and turnover between November 2015 and November 2016 across all three wards.

Total sickness was 6.2%

Total turnover of all substantive staff was 3.8%

Staff we spoke with reported a high use of agency and bank staff especially at night and at weekends. We reviewed the electronic staff rotas for each ward from 1 January 2017 to 4 February 2017. Ward staff worked a combination of shifts over three days and rotated from day shifts to night shifts. All three wards used contracted qualified agency staff in addition to the regular staff. A number of agency staff had contracts to work at York House to provide consistency of staff on duty. Rotas clearly indicated the regular use of qualified and unqualified agency staff use on all three wards from two different agencies. All three wards used contracted qualified agency staff in addition to the regular staff at night.

There was a higher reliance on bank or agency staff at weekends and night shifts with agency staff making up the majority of staff on duty during most nights. For example, The Dales used the highest number of qualified agency staff to cover night shifts (30 out of 35 nights 86%), The Wolds used 16 (46%), and The Moors used the least qualified agency staff (11 out of 35 nights 31%) However, 26 of the night shifts (86%) on The Dales were covered by staff from one agency. We saw that there was consistency in the staff used which meant agency staff were familiar with the ward. This agency also provided induction and training required for York House.

York House reported how they ensured that staffing levels were safe for the service they provided to their patients. They estimated the current establishment against the requirements for staffing levels according to bed occupancy. The service employed additional clinical staff working in full and part time posts who were not included in the ward establishments. This included one clinical lead and one senior staff nurse for each ward. Senior staff nurses worked mostly between the hours of nine and five over seven days and provided cover as required on a day-to-day basis. Therapy assistants provided activity sessions on all three wards.

Staff planned rotas and used bank and agency staff to maintain staffing levels. In addition, regular staff worked additional hours or overtime to maintain adequate staffing levels. Staff also moved to work on a ward that was short-staffed if there was sufficient staff on their ward. Managers adjusted staffing as required to meet additional patient needs such as increased observations.

Staff were visible in communal areas at all times and offered regular one to one time with patients. This included rehabilitation support workers who acted as key workers. This was in addition to the time patients spent with therapy and clinical staff. There was sufficient staff trained in the prevention of management and aggression to carry out physical interventions and to support patients leave.

Members of the multi-disciplinary team such as psychology, speech and language therapy, occupational therapy, physiotherapy, social worker and psychiatrist were not included in the ward establishment but provided additional interventions to patients across all three wards during weekdays.

Managers were available during the day on weekdays and provided 24 hour on call cover at evenings, weekends, and bank holidays. Staff told us they could access senior managers when needed.

York House had adequate arrangements for medical cover. York House employed one 0.8 whole time equivalent consultant psychiatrist who was available over five days per week. A local mental health hospital provided cover for the consultant psychiatrist when they were unavailable. Nurses called 111 or the out of hours GP service for urgent medical matters.

At our last inspection in February 2016, we found that staff did not complete and update their mandatory training in accordance with agreed standards to ensure they maintained the necessary skills to meet the needs of the people they care for and support. At this inspection, we found that York House had made improvements in staff compliance with mandatory training. The hospital introduced a new online training system in May 2016 to support staff to complete their electronic mandatory training and arranged additional face-to-face training

sessions throughout November and December 2016. This improved the overall compliance rate to meet the required hospital target of 85%. The hospital recognised that it was more difficult for bank staff to complete their mandatory training compared to permanent and regular contracted staff and did not use them to cover shifts until staff completed their required training. Managers used agency staff who had completed the required training. They worked closely with the managers from the agency to ensure staff training was adequate and up to date.

Mandatory training compliance was over 75% in 17 of the 19 courses including safeguarding adults, infection prevention, and control, Mental Health Act Mental Capacity Act and Deprivation of Liberty Safeguarding. Mandatory training compliance with emergency life support was 66% overall and immediate life support 56% overall. These were the only two mandatory courses that staff had not achieved the hospital target of 85%. Managers had oversight of this and a plan in place for staff to complete their training in 2017. We checked the duty rotas for one month for all three wards to see if there was sufficient numbers of appropriately trained staff on duty. All the duty rotas identified how many staff were on duty at every shift who were trained to use an automated external defibrillator. The number of suitably trained staff to use a the defibrillator ranged from three to seven staff on night shifts, and four to seven staff on early and late shifts. However, training compliance was lower than 75%, which meant there was a potential risk to patient safety.

Assessing and managing risk to patients and staff

York House did not have a seclusion room and reported the service did not use seclusion of long-term segregation between 1 May 2016 and 1 November 2016.

The Dales reported 63 incidents of restraint (the highest number of incidents) which involved nine different patients. The Moors reported 20 incidents of restraint on seven different patients and The Wolds reported 16 incidents of restraint on three different patients within the same period. The service reported two incidents of prone restraint. This happens when staff restrain a patient on the floor with their face facing downwards. The Dales reported all two incidents of prone restraint where the patient put themselves into that position before staff rolled the patient in to a safer position. Both incidents occurred in one month and involved one patient.

Staff carried out pre-admission assessments with patients referred to the service. They did not admit patients who had a history of suicidal behaviour within the past six months.

When patients were admitted to the ward, staff carried out a multi-disciplinary risk assessment and reviewed this at the patients multi-disciplinary team meetings or sooner if risks changed. Where staff identified patients at risk of suicide, they managed these risks according to individual patient care plans. The hospital supportive observation protocol identified how staff carried out different levels of observation depending on the 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. For example, staff observed one patient at 15-minute intervals during the day and corridor observations at night until awake. Another patient had a safeguarding plan that involved staff carrying out strict corridor observations in addition to 15-minute observations. This was included in a safeguarding plan which clearly identified how staff carried out corridor observations. However, we did not see reference to corridor observations in the hospital protocol. All three wards admitted patients who required one to one observation. We observed staff were always present in communal areas and they carried out patients' individual observations according to the hospital protocol. However, bedroom doors did not have viewing panels, which meant that when patients on one to one observation went into their bedrooms staff remained outside the room with the door open or stayed in the room.

We reviewed 16 care and treatment records of patients including their risk assessments across all three wards and found staff reviewed risk assessments and kept them up to date. Staff used a risk assessment tool that was appropriate for people with an acquired brain injury. We observed a multi-disciplinary team meeting where

discussion of an individual risk assessment took place. These meetings happened once every week and every patient was discussed on a four weekly rota or sooner if required.

The hospital supported the use of any restrictions with individual assessments such as allocated smoking times, covert medication and access to food and drinks. We reviewed the care plans of patients with these restrictions and saw that capacity assessments and best interest decisions supported the use of restrictions.

At our previous inspection in February 2016, we found that the hospital did not have a policy in place about the locked doors, which is required to protect the rights of patients who are not detained under the Mental Health Act. At this inspection, we saw that all three wards displayed appropriate information about how informal patients could leave the ward.

York House employed staff to deliver training in the prevention and management of violence. This included a five-day course and an annual two-day refresher. This was not mandatory training, however training compliance was above 85% overall. Staff followed the provider's policy about positive approaches to challenging behaviour and the use of least restrictive practices. Staff were taught to use verbal and non-verbal de-escalation techniques first and record all physical contact as restraint. This is good practice according to current national guidelines including the Mental Health Act, Mental Capacity Act, and Human Rights Act. Training staff reviewed all incident forms that involved the use of restraint and delivered bespoke staff training for individual patients. The service used a multi-disciplinary approach to manage patients' challenging behaviours. Assistant psychologists used individual patient information such as triggers and mood to support staff to manage physical aggression in the least restrictive and most effective way. Staff incorporated this into patients' care plans and we observed how staff managed challenging behaviour in the least restrictive manner during our inspection.

Where staff assessed patients who lacked capacity, staff documented the use of restrictive interventions in patient's care plans as a last resort to support patients meet their personal care needs and the administration of medication.

At our previous inspection in February 2016, we found that staff did not always act in accordance with national guidance after they administered rapid tranquillisation to patients. Rapid tranquilisation is when staff administer medicines to patients to help with extreme episodes of agitation, anxiety, and sometimes violence. It is important that staff carry out physical observations with patients as rapid tranquillisation can cause physical health issues such as cardiac arrest. At this inspection, we found the hospital had not made sufficient improvements after the use of rapid tranquillisation. The hospital had updated their policy to include National Institute for Health and Care Excellence guidance. This included monitoring forms for nurses to document physical health observations such as temperature, respirations, pulse, and blood pressure at set intervals. Nurses received training about completing physical health observations and completed care plans for patients who received rapid tranquillisation. The service carried out an audit on the use of rapid tranquillisation between 1 October 2016 and 31 December 2016 and found that nurses did not always request a medical review immediately after they administered rapid tranquillisation. We reviewed one record of rapid tranquillisation dated in January 2016. Nurses did not fully complete the required documentation for physical health monitoring according to the policy and when we checked the monthly medication audit tool, the nurse had not identified this as an issue. Following the inspection, we checked six more physical health monitoring records for patients who had received rapid tranquillisation during November 2016 and January 2017. We found that staff did not consistently document physical health monitoring as required by the hospital policy and current best practice guidance. We identified this as a continued breach of regulation according to The Health and Social Care Act 2014.

We looked at 10 medicines related records for patients across all three wards. We could not see a legible or printed name of the prescribing doctor or their General Medical Council number, which meant it was unclear who had prescribed the medication. This was not in keeping with the hospital medicines policy.

There was no record of medicines reconciliation in the patient's notes. The visiting pharmacist told us they carried out medicines reconciliation and recorded this in their own notes that do not form part of the patients care record. This meant there was no way of evidencing that medicines reconciliation occurred and the patient's record was not a complete record.

Good

Services for people with acquired brain injury

We observed that staff were not bare below the elbow and did not carry out the correct hand hygiene procedures when they administered medication to patients. This was not in keeping with infection prevention and control guidelines.

The hospital had policies and procedures in place to safeguard patients. Safeguarding adults and children training was mandatory for all regular and bank staff. Safeguarding adults was 99% and child protection was 84% compliance. Staff knew how to raise safeguarding concerns through their electronic reporting system and 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. 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, who confirmed safeguarding reporting from York House was generally good.

We looked at medicines management across the hospital. The hospital had a service level agreement dated March 2016, which set out the arrangements for pharmacy services from a local NHS Trust. York House did not have an identified accountable officer for controlled drugs because they were exempt from this requirement. However, the local service level agreement indicated that York House would appoint an accountable officer. We saw evidence of their exemption until December 2017. Each ward had an allocated pharmacist and pharmacy technician. The pharmacy staff were responsible for checking patient's medication on admission, and carrying out specific audits such as missed signatures on medication administration cards and compliance with the Mental Health Act. We found some gaps in the nurses recording of administration but saw errors such as these were reported and acted on through the monthly medication audit completed by nursing staff on all three wards.

At our previous inspection in February 2016, we found that audits of medicines management listed a number of issues, which were not analysed and learned from in order to prevent re-occurrence of medicines related incidents. At this inspection, we saw that the hospital had clear evidence of how they acted on issues identified from audits and medication related incidents. We reviewed the medication audit from January 2017 for each ward. The audits included medication storage, documentation, environmental checks, staff compliance with the hospital rapid tranquillisation policy, and the Mental Health Act. We saw that managers discussed trends and actions from ward audits at their quarterly drugs and therapeutics meetings. For example, the ward audits identified that patient photographs with other person identifiable information should be with each file. This was discussed at the drug and therapeutics meeting and we saw this was in place during our inspection.

Nurses reported medication errors through the hospital incident reporting system. We reviewed the medication related incidents from April to September 2016. Across the three wards there had been 21 reported incidents. This included patients missing their medication, missing administration signatures, wrong dose of medication and near misses. Since our last inspection in February 2016, the hospital reviewed and updated their medication protocol and carried out root cause analysis to understand why incidents occurred. The drug and therapeutics meeting and governance arrangements ensured that managers shared any lessons learned with staff. We saw one example of how the hospital shared learning form medicine related incidents via a lessons learnt bulletin dated July 2016.

Staff ensured there were safe procedures should children under 18 years visit the hospital. York House had an agreement with a local hospital within the same grounds to book their family visiting room, which was located away from the main ward areas.

Track record on safety

York House reported no serious incidents.

Reporting incidents and learning from when things go wrong

All staff received mandatory training at their induction and every two years about how to complete incident forms. When incidents occurred, staff received feedback via a range of methods. This included individual supervision, emails, staff meetings, bespoke tutorials, and de-briefs. However, attendance at de-briefs and tutorials was dependent on staff availability to attend.

Managers recorded all incidents monthly and reported then to the organisation's health and safety team. We reviewed the 79 incidents that occurred over one month,

Good

Services for people with acquired brain injury

which included falls, aggression, self-harm, medication errors, and other incidents. Staff gave a description of the incident however; it did not indicate the level of harm sustained as a result of the incident.

We reviewed the 13th version of the hospital's lessons learned bulletin that shared outcomes and learning from two patient safety incidents. Following our previous inspection in 2016, the hospital had developed the "safe room" to make improvements in safety. This was as a result of a serious incident that occurred in another hospital for people with acquired brain injury.

Duty of Candour.

York House reported no incidents that required the service to meet their requirements of the Duty of Candour. However, York House had an up to date openness and transparency "Duty of candour" policy, which was available to staff on the electronic system. This policy was not kept in the same place as other polices that related to York House which meant staff might not be aware of the policy. Staff we spoke with understood the requirement to be open and honest with people when things go wrong. Relatives we spoke with told us that staff kept them fully informed of any incidents that involved their relative.

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Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed 16 care records of patients across the three wards and found that the multi-disciplinary team completed a comprehensive assessment for every patient after admission. Most patients were admitted to The Dales for their initial assessment. However, staff always admitted female patients to The Moors, as this was the only ward with mixed sex accommodation. Staff assessed patients through individualised programmes, a range of activities and structured one to one time with members of the multi-disciplinary team. The clinical leads produced care programme approach reports that included details of the patient's assessment over the 12-week period. This included clinical history, clinical reports, risk management, Mental Health Act, and recommendations for the next period of rehabilitation.

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Staff ensured that patients received a physical health examination on admission and monitored any ongoing physical health problems. Patients had individual care plans about their ongoing physical health needs such as diabetes and epilepsy.

Staff kept care records up to date and ensured they covered a range of patients' needs including social and emotional needs. Staff completed personalised patient care records and where possible included the views of the patient about their care. All three wards focused on what recovery meant for each individual patient, and identified their strengths and goals.

Staff kept all information relating to patient care in a secure place where staff could access it if they needed it. Staff completed a combination of paper and electronic records and these were transferred with patients if they moved wards within the hospital. Staff referred to visual boards in their duty rooms for a range of information about patients' current care. Although only staff had access to this room, it was possible for others to view the information through a window. This meant that the information might not be confidential.

Best practice in treatment and care

The neuropsychologist led on the integrated model of care, based on a neurobehavioural approach and compassion focused therapy. The neurobehavioural model is a recognised model of treatment for people with an acquired brain injury who are in the community. It is based on helping people to gain social skills and maximise their independence. Compassion focused therapy is a form of psychotherapy that uses recognised psychological therapies to help people manage their emotional responses.York House developed the integrated model to meet the needs of their patients and to support the staff who care for them.

Members of the multi-disciplinary team provided evidence-based interventions and therapies for patients. The psychiatrist prescribed medication according to The Maudsley Guidelines to support patients' health and

recovery. We reviewed 10 prescription charts and looked at medications that the doctor prescribed. We found that medication was always prescribed and monitored according to the guidelines. For example, patients who received high doses of anti-psychotic medications had a monitoring form and red card system in place to ensure they received all the required physical health checks. Anti-psychotic medication is prescribed to treat mental health conditions and has side effects that can affect a patient's physical health. It is important that staff carry out physical health checks especially when patients are prescribed high doses of this medication as they are at greater risk of experiencing side effects. We reviewed the physical health monitoring for one patient prescribed high dose anti-psychotic medication, which was fully completed.

The psychology team offered recognised psychological assessments and therapies to patients based on their individual needs. They had a range of assessment tools available to use. This included an assessment tool called the Overt Aggression Rating Scale Modified for Neurobehavioural Rehabilitation, which psychologists used to examine changes in levels of aggression. Psychologists completed formulations based on compassion focused therapy and the neurobehavioural approach. We saw how staff used the care programme approach framework to support patients' recovery.

The speech and language therapists referred to The Royal College of Speech and Language Therapists Clinical Guidelines and used a range of evidence based assessment and monitoring tools. Staff completed a La Trobe communication questionnaire and the Measure of Cognitive Linguistic Abilities with patients when appropriate. Patients with specific communication needs had communication passports and communication aids. We reviewed two care plans for patients with specific communication needs and saw care plans referenced The Royal College of Speech and Language Therapists Clinical Guidelines.

The occupational therapists contributed to patient assessments with functional assessments and set goals with patients to monitor their progress. Where appropriate they used evidence based assessment and screening tools such as the apraxia screening tool.

Patients at York House had good access to physical health care. The hospital employed a registered general nurse who developed physical health plans and monitored patients' ongoing physical health needs. A health plan is recommended by the National Institute For Health and Care Excellence. Nurses completed comprehensive physical health plans that included physical health checks, nutritional and skin integrity monitoring. Nurses reviewed care plans related to diabetes and epilepsy in accordance with National Institute for Health and Care Excellence guidelines. Staff registered all patients with a local GP surgery and supported patients to attend the surgery where possible. Staff from the local GP surgery visited the hospital twice weekly to see patients who were not able to visit the surgery. The GP accessed the patient's notes, which meant there was good communication about patients' physical health care. Staff offered all patients an initial health check and support such as smoking cessation. Nurses ensured that patients had access to specialist care such as options, dentists, chiropodists, and hospital specialists. In addition, dietician, speech and language therapists and occupational therapy staff assessed patients' nutrition and hydration needs and ensured patients' received the appropriate support. This included communication aids, special diets, and adaptive cutlery.

York House reported on national outcome measures prescribed by United Kingdom Rehabilitation Outcomes Collaborative. This meant that progress made by patients at York House was open to external scrutiny and comparison with other brain injury rehabilitation services. Clinical staff participated in a range of audits to monitor and improve the service they provided for patients. This included audits of the Mental Health Act and Mental Capacity Act, medication related audits, and safeguarding procedures. We saw evidence of monthly medication audits carried out on each ward and evidence of a safeguarding audit with clear outcomes and actions

Skilled staff to deliver care

York House had a wide range of professionals who were appropriately trained to meet the needs of the patients at York House. This included nurses with a variety of professional qualifications such as mental health, general and learning disability, consultant psychiatrist, neuropsychologist, psychologists and psychology assistants, speech and language therapists, occupational therapists, physiotherapists and social worker.

All staff employed by York House received a comprehensive induction when they started work. This included both

classroom and practical learning to prepare staff for their role. This included elements of the Care Certificate standards for rehabilitation support workers. Specific training for all staff included brain injury, nutrition and hydration, equality and diversity and dignity and respect.

At our previous inspection in February 2016, we found that staff had not received regular appraisal or supervision, in accordance with the hospital policy. York House had a target of 85% of staff to receive three clinical supervision sessions every 12 months and an annual appraisal. The hospital reported 100% of staff received three supervisions during the 12 month period between 14 November 2015 and 15 November 2016. At the time of our inspection in February 2017, 94 % of non-medical staff had received an appraisal. The hospital had a matrix that outlined the arrangements for supervision and appraisal across all three wards. Senior managers had oversight of all staff supervision and appraisal via an electronic spreadsheet. We looked at ten staff personnel files and saw evidence of clinical supervision documented in all staff personnel files. Most staff we spoke with told us they had received regular supervision and an appraisal. However, York House did not include bank staff in their supervision and appraisal arrangements. This meant that despite the regular use of bank staff to maintain staffing levels, managers did not monitor their performance in the same way as employed staff. We checked the supervision, appraisal, and re-validation of medical staff and saw evidence that this was all completed.

Staff had access to specialist training that was identified at their performance and appraisal reviews. Staff told us they had attended role specific training such as compassion focused therapy, music therapy and veteran awareness training. Nurses held training days every three months, which provided an opportunity for peer group learning, and learning disability nurses had the opportunity to attend a learning disability conference. All nurses attended specific medicines related training.

Managers supervised newly appointed staff over a six-month probationary period and took action if any issues arose. Managers used the hospital disciplinary procedures to deal with any poor performance of regular staff. If managers were concerned about agency staff performance issues, they took immediate action and communicated with the relevant agency. Managers also identified positive staff performance and we saw a number of staff had recognition awards in their personnel files.

Multi-disciplinary and inter-agency team work.

The multi-disciplinary team held once weekly meetings to review individual patients care and treatment. Staff invited all patients to attend their meeting and discussed each patient on a four weekly rota or sooner. Staff included care plans, risk assessments, mental capacity, and discharge arrangements in their discussions. We observed one meeting attended by a range of professionals including the neuropsychologist, psychiatrist, nursing staff and advocate. The patient was asked but declined to attend. Staff told us that they always invited patients and families and gave feedback if they did not attend. We observed that all staff contributed equally and effectively during the meeting and discussed the patient's care and treatment. Staff supported patients to prepare information before the meeting and recorded the outcome of the meeting. We saw evidence that staff recorded this information in individual patient involvement records. Patients and families we spoke with told us they were involved and kept informed of plans for care and treatment. Rehabilitation support workers attended the meeting if requested by the patient. However, two staff who had attended the meeting felt not all members of the multi-disciplinary team respected their views.

Staff held monthly clinical team meetings. We observed one meeting that was attended by representatives from all members of the multi-disciplinary team including psychology, occupational therapy, speech and language therapy, physiotherapy, social work and medical and nursing staff. The meeting discussed a range of topics affecting the service such as, clinical, staffing, and training issues. Rehabilitation support workers and nursing staff from the wards did not attend these meetings. However all staff, including those on night duty had access to regular staff meetings. We reviewed minutes of meetings that occurred during December 2016 and January 2017 where staff and senior managers met to discuss current issues. All staff had opportunity to attend team away days within their staff groups.

Nurse handovers were planned for 20 minutes three times per day when nurses changed shifts. We observed three nurse handovers that occurred on each ward when staff

from the early shift passed on information to staff on the late shift. Staff used a handover template, however, we found inconsistencies in the structure and effectiveness of the handover. One handover lasted 10 minutes and the nurse gave a brief overview of the patient's progress from that morning and from the GP visit the previous day. Staff did not discuss the patients care plan, observation levels or risk assessments. However, this information was available for staff on a visual board and staff appeared to know the patients well. Nurses gave accounts of the previous 24 hours and previous two days at the other two handovers and included information about observation levels and current care plans.

Therapy staff such as occupational therapists and psychologists did not work the same shift pattern as ward staff, which meant they had a separate handover together each day when they started work at 09.00am. They used information gathered from each ward to plan their work and complete therapy schedules for individual patients. Ward staff told us they were not confident that patients always had the therapy time allocated to them. This was because sometimes patients declined to participate, patient's risks had changed, or staff were not available. Ward staff reported that they were sometimes unclear about the whereabouts of clinical staff and if they were available for scheduled patient therapies.

The hospital worked with teams from all over the country and staff described variability in working relationships with teams from outside their organisation. However, staff at York House worked in a proactive manner to ensure they communicated with all teams outside their organisation. This included inviting professionals to care programme approach meetings. Staff described effective working relationships with the local authority, advocacy, and GP practice and we saw how staff shared relevant information.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

We took into account the two Mental Health Act review visits carried out since our last inspection in February 2016. The majority of patients at York House were detained under the Mental Health Act at the time of our inspection.

The service provided mandatory Mental Health Act training to all staff and reported that 87% of staff had received this training. This was above the hospital target of 85%.

At our inspection in February 2016, training and associated policies had not been updated to reflect the changes within the Code of Practice in April 2015 and nurses were not aware of the changes. At this inspection, we found that all policies had been amended in accordance with the changes in the Code of Practice. There was good adherence to the Mental Health Act and the Mental Health Act Code of Practice. Staff training included the necessary changes and nurses were aware of their responsibilities. The hospital Mental Health Act staff were knowledgeable and available to support staff with advice when required. All nurses we spoke with valued this support, which included audits of their compliance with Mental Health Act and legal advice.

Staff kept prescription charts and any required Mental Health Act documentation located in the same file. All medication prescribed appeared to be authorised and medical staff recorded and reviewed the patient's capacity to consent to medication. This included evidence of authorisation by Second Opinion Appointed Doctors. This is a legal requirement for patients who lack capacity to consent to take medication and detained patients' with capacity who refuse to take medication after three months. It is important that all information is correct and kept together so that nurses can check they are legally authorised to administer medication to patients.

At our last inspection in February 2016, the hospital did not have a locked door policy or information that informed informal patients how to leave the wards. This is important to protect the rights of patients who are not detained under the Mental Health Act. At this inspection staff, all three wards were locked and the service had a locked door policy that adhered to the current Mental Health Act Code of Practice. Staff informed and supported patients to understand their rights under the Mental Health Act. Staff explained patients' rights to them on admission and again at regular intervals such as following tribunal hearings or section renewals. All wards displayed a range of information that included a notice to tell informal patients how they could leave the ward. Information was available in other formats such as easy read and staff took account of individual patients communication needs.

All detention paperwork was fully completed, up to date and stored correctly. Mental Health Act staff carried out a range of audits on a regular basis. This included audits of T2 and T3 certificates, section 132 rights, and section 17

Good

Services for people with acquired brain injury

leave. These are all forms that are legal requirements when patients are detained under the Mental Health Act. At our previous inspection in February 2016, we found several issues with section 17 leave forms. This included nurses not fully completing the document before leave and documenting the patient's view of their leave. A section 17 leave form is a legal requirement to authorise hospital leave for patients who are detained under the Mental Health Act and must include this information. We saw that the audit of Section 17 leave forms now included those areas for improvement and nurses recorded the required information.

The hospital ensured that all patients had access to an independent mental health advocate. Staff referred all detained patients automatically to the independent mental health advocate who contacted patients and attended certain meetings.

Good practice in applying the Mental Capacity Act

York House provided mandatory Mental Capacity Act training and reported that 87% of staff had received this training. This was above the hospital target of 85%.

The hospital reported 14 applications for the Deprivation of Liberty Safeguards between 1 May 2016 and 31 October 2016. The Wolds and The Moors reported six applications each and The Dales reported two applications during this period. All applications were authorised or waiting to be authorised by the local authority. The hospital kept in touch with the local authority about progress with the applications that were waiting for authorisation.

At our previous inspection in February 2016 we found that the Mental Capacity Act policy was out of date, however York House now had an up to date policy in place and available for staff. The Mental Health Act lead also acted as a lead for Mental Capacity Act and Deprivation of Liberty Safeguards and carried out audits to ensure appropriate use of the Mental Capacity Act. The forms used to document the Mental Capacity Act assessments had been improved since our last inspection in February 2016 and ensured that staff documented all the relevant information.

Staff were very clear about the lead role and understood their responsibilities under the Mental Capacity Act. The patients at York house had multiple needs, including those who lacked capacity and experienced communication difficulties. This required very complex decision-making and required staff to give patients every opportunity and assistance to make specific decisions. We saw that staff did all they could to support patients to make decisions about their care and treatment. Staff carried out capacity assessments, best interests meetings, and referred to care plans that took account of least restrictive practice and individual wishes where possible.

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support

We observed lots of examples of staff interaction during our inspection including one to one and group interactions. We also carried out observations that were more formal and used the short observation for inspection framework to record staff interactions with patients. All interactions between staff and patients we observed were positive. Patients and their relatives we spoke with said staff were caring and respectful. Staff and patients appeared to know each other well and staff used preferred names when they spoke with patients. We observed how staff managed a situation when a patient was distressed and threatening towards others. Staff supported the patient in a manner that was respectful and protected the patient's dignity and that of others.

The involvement of people in the care they receive

Patients were involved in decisions about their care and treatment and could provide feedback about the service. When patients were referred to the service staff provided information and supported them and their families to visit before admission if possible. We saw an example of the York House welcome guide for patients. This was provided in pictorial and easy read format and appropriate for patients admitted to York House. If patients moved between wards following admission , staff included patients in decisions about the move and prepared them in advance with visits wherever possible.

At our previous inspection in February 2016, we did not see any evidence that staff gave patients' copies of their care plans. At this inspection, we saw there had been an improvement and staff and patients told us they had offered and received care plans. Some patients we spoke with were aware of their care plans but said they were not

Good

Services for people with acquired brain injury

interested in having a copy. We saw that staff documented patient's decisions about their care plans. Staff routinely invited patients and their carers where appropriate to their clinical meetings. If patients did not attend, staff gave feedback about the outcome of those meetings as soon as possible. Key workers met with patients to assist them in presenting their needs and goals to the multi-disciplinary team before their meeting. Relatives we spoke with felt involved and informed of their relatives care and treatment and said staff considered their views.

Patients had good access to activities throughout the week. Patients had very individualised care plans that took into account their strengths and goals towards increased independence. Staff encouraged patients to make choices about their activities and therapies and all patients had an individual activity schedule. This included goals for one to one therapy time in the hospital in addition to community and vocational activities. We noted that rest time was included in the activity schedule in recognition of the patients' physical activity levels.

Physical activities were varied and challenging and included fishing, canoeing, rock climbing, skiing, and abseiling. This was in addition to other activities such as music therapy, reminiscence, and games. Clinical staff and therapy assistants worked from Monday to Friday during the hours of 09.00am until 5.00pm and ward staff supported activity at evenings and weekends. Staff worked together from across all three wards to support patients' communal activities such as Christmas celebrations. They used established links with the local authority and charities to support a variety of sporting and vocational activities. However, some patients we spoke with said they felt bored. Staff said facilitating activities was more difficult at weekends because clinical and therapy staff did not work at those times. We observed staff spending time with patients on an individual and group basis and heard many examples of staff supporting patients to take part in a variety of activities across seven days per week.

York House used a local independent advocacy service that visited patients on all three wards on a weekly basis. The advocate attended a range of meetings about individual patient's care such as care programme approach meetings and best interest meetings. The advocate supported patients and their relatives in matters related to complaints and safeguarding. The advocacy service described good working relationships with staff, which enabled them to provide good support to patients.

Patients and their relatives had opportunities to be involved in decisions and feedback on the service they received at York House. This included satisfaction surveys and involvement audits. We saw examples of staff acting on patient feedback such as the "you said, we did" display and the ideas and actions group. This was a regular group held with patients from all three wards to update and involve them in decision-making and raise any concerns about the service. Staff kept minutes of the meeting, which were available for patients. Managers had oversight of feedback from patients and included this in their quarterly governance report. Patients were not directly involved in staff interviews, however newly appointed staff told us they were introduced to patients as part of their interview.

Staff documented if patients had advance decisions or statements in place at the time of their admission to hospital. Advance decisions and statements are decisions you can make when you have capacity about your care or treatment at some time in the future. It is important that clinicians know about these decisions so that they consider these when planning care and treatment.

Are services for people with acquired brain injury responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

York House reported the average bed occupancy rates between 1November 2015 to 31 October 2016;

The Dales 66%

The Moors 81%

The Wolds 90%.

York House reported on the average length of stay of patients discharged in the previous 12 months as at 31 October 2016; The Dales was nine months, The Moors, four and a half years and The Wolds, 10 years. The length of stay

reflected the function of each ward. The Dales admitted male patients for assessment and treatment and moved patients on to another ward at York House for their continued rehabilitation and recovery if appropriate. Female patients were admitted to The Moors because it was the only mixed ward. This meant that female patients could not move to another ward at York House. Following assessment female patients continued their rehabilitation on The Moors or were discharged to appropriate services. York House described The Wolds as a slow stream rehabilitation ward and only occasionally admitted patients directly to the ward. Some patients on The Wolds had been at York House for many years. We reviewed three care records for patients on The Wolds and saw that all three had discharge plans. Staff discussed discharge plans at multidisciplinary and care programme approach meetings. The service involved families, other agencies, and commissioners in discharge plans. However, staff identified that some patients had lengthy hospital admissions because of the complexity of their needs and lack of suitable alternative placements.

Due to the specialist nature of the service, York House admitted patients from all over the country, which meant there was a high number of out of area placements. This meant it was not always possible for patients to be near their families and friends. However, York House supported patients to keep in touch with people who were important to them. Patients and relatives we spoke with said they were able to maintain contact with each other. When patients went on leave from the hospital, they always had access to their bed when they returned. York House prepared in advance for patients' discharge so that arrangements occurred at suitable times for patients.

Members of the multi-disciplinary team held weekly referral meetings and carried out pre-admission assessments with people who were referred to the service. This was to ensure the service could meet the needs of the patient before agreeing to an admission. We observed one referrals meeting where staff held detailed discussions. Staff gave recommendations for care and treatment if York House was not suitable. York House aimed to complete an assessment review within one week of the referral to the service. Staff agreed a date for admission following the local commissioner agreement and bed availability. York House reported the actual time from referral to initial assessment was two weeks and from assessment to the onset of treatment as six months.

York House received 19 referrals between February 2016 and December 2016 and accepted 10 patients who were suitable for admission. York House discharged 11 patients from across all three wards between 5 January 2016 and 17 January 2017. We looked at discharge records and saw that patients were discharged to a variety of places across the country. This included patients' own home, alternative hospitals, supported living schemes and care homes. Staff planned discharge with patients in a structured way, including periods of leave where possible and joint working with others to promote a successful discharge for patients.

York House reported two delayed discharges in the previous 12 months as at 31 October 2016. A delayed discharge is when a patient remains in hospital for non-clinical reasons. Staff told us this only happened when there were difficulties with finding appropriate placements or funding.

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The facilities promote recovery, comfort, dignity and confidentiality

At our inspection in February 2016, we found that the hospital did not provide adequate space for patients to receive one to one intervention in rooms that ensured their privacy and dignity was not compromised. At this inspection, we found the service had made improvements and there was a full range of rooms and equipment to support patients' care and treatment. This included designated room on each ward that staff booked out for planned one to one interviews with patients. All wards had communal lounge areas and dedicated space for activities. We saw one dedicated room that contained physiotherapy equipment that was accessible for all patients. The hospital had an up to date visitor policy that welcomed and supported visitors.

Staff supported patients to ensure they kept in touch with others. Patients had access to mobile phones and electronic devices to contact family and friends in addition to pay phones and cordless phones for private calls. Patients and relatives told us they could speak with each other at any time.

Patients had access to outside space in the grounds of the neighbouring hospital. Most of the patients were on observations or had impairments that meant staff supported them to leave the locked ward areas. During our inspection, we observed staff escorting patients outside for

activities and smoke breaks. Some patients who smoked had set times during the day that they could go out for a cigarette. We saw these times displayed on The Wolds. We looked at the care plans for two patients with restrictions in place. Both patients had individual care plans and risk assessments based on their clinical needs to support these restrictions.

The catering arrangements at York House were good. We asked patients about their views of the food provided and observed the food quality over lunchtime. Patients gave mostly positive feedback about the food choices, quantity, and quality. The food was delivered from a neighbouring hospital and served from heated trolleys by ward staff. Staff supported patients to choose their menus in advance and provided feedback to the chef from patients about how the food could be improved.

Patients had access to drinks and snacks throughout the day. However, on The Wolds for example we saw access to cold drinks from the water fountain was restricted because there was no cups ready for patients to use. A sign on the wall informed patients to ask staff when they wanted a drink. Staff explained that cups were not readily available because some patients were at risk of excess drinking to an extent that they could cause significant physical harm. Staff assessed this as least restrictive way to manage this issue on the ward. Those patients who were not at risk of harm from excessive drinking accessed the locked kitchen area and others had their own cups. We also observed staff offer drinks to patients throughout the day.

Bedrooms were spacious and comfortable and patients personalised their rooms with things that were important to them. Patients could store their personal belongings securely in each bedroom. Staff offered patients keys to their bedrooms and supported patients to access their bedrooms at all times. Most bedrooms had privacy screening over the windows that looked out into the hospital grounds. Where this was not in place, it was because individual patients had chosen not to have this in place. Staff told us that did all they could to maintain patients' privacy and dignity. However, we were concerned that people in the hospital grounds could potentially see patients in those bed rooms without privacy screening.

York House offered a wide range of activities that were individually planned as part of patients' rehabilitation and recovery.

Meeting the needs of all people who use the service

York House had adjusted the hospital to ensure it was accessible for all people who used the building. The hospital had an automatic, push button entrance door into the main reception area. Staff assisted patients to open other doors that did not open automatically. The lift accessed all floors, which meant people with impaired mobility had access to all wards. Staff had access to hoists and specialist equipment to support patients with impaired mobility.

All wards displayed a range of information that included information about local services, how to complain, patients' rights, and the Care Quality Commission. Some of this information was displayed in easy read format and staff told us they could access information in different languages if needed.

Some patients at York House had specific communication needs and aids to help them communicate with others. Staff were knowledgeable about patients' specific communication needs and supported patients to communicate. This included sign language, easy read and large print books, and digital equipment. The hospital had access to interpreters if required.

The head chef at the neighbouring hospital and staff at York House worked together to ensure that food was available to suit all patients, including cultural, religious and nutritional requirements.

Staff supported patients to meet their spiritual needs. Staff facilitated religious visits to the ward and supported patients to attend religious ceremonies of their choice in the community.

Listening to and learning from concerns and complaints

York House reported 10 complaints between December 2015 and September 2016. Managers investigated the complaints and found one complaint upheld, two partially upheld, and seven not upheld. None of the complaints were referred to the Parliamentary and Health Service Ombudsman. Complaints were about patients not happy with their care or the way staff treated them and included complaints from patients and from families. York House had a complaints policy that was in date and accessible to staff via their electronic system. We reviewed four complaints and found that the process for people to raise

Good

Services for people with acquired brain injury

their complaint either formally or informally was straightforward. Staff investigated and responded to the concerns raised and supported people to raise their complaint.

York House reported 13 compliments received in the last 12 months, as at 31 October 2016.

Patients and relatives told us they felt confident and knew how to raise a complaint if they needed to. Staff were aware of how to deal with complaints and received any relevant feedback through staff meetings or supervision if required. Managers monitored the numbers and types of complaints and the progress of investigations as part of the hospital governance processes. This ensured that staff adhered to deadlines and people received a timely response to their complaint.

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

Good

Vision and values

York House used the Disabilities Trust mission statement and values. This was stated as;

Inspired by the potential of people with disabilities, we are working in partnerships to provide the highest quality services for those within our area of expertise.

The values of York House were:

People with disabilities are at the heart of all that we do. While meeting care and support needs, we will endeavour at all times to enhance their independence and promote the rights of disabled people as equal members of society. We believe in:

•the honesty and integrity of everyone in, and associated with, the Trust

•respect and support for each other and our respective roles

•accountability and responsibility at all times

•working in partnership with others to the mutual benefit of people with disabilities.

We will:

•deliver services to the highest possible standard

•be business-like and professional but caring

•aim for financial viability

•be forward thinking, innovative and pioneering

•work towards measurable quality outcomes

•raise standards within the sector.

Staff were very proud of the work they did to support patients' recovery and independence and wanted to offer the best care they could. This was in keeping with the organisation's values. The hospital embedded these values and behaviours within their recruitment, induction, supervision, and appraisal processes. The organisational model of compassion focused therapy and bespoke tutorials led by the clinical team supported staff to understand their own values, behaviours, and attitudes. The policies and procedures at York House underpinned the organisation's values.

All staff knew who the senior managers were at the hospital and identified them by name and professional role. Staff were very clear about who had the lead role for safeguarding and Mental Health Act and Mental Capacity Act but less clear about the roles and responsibilities of other senior managers. However, staff appreciated that managers, although busy, were accessible and had an open door policy.

Good governance

Following our inspection in February 2016, we issued four requirement notices and told the hospital it must make improvements. This included improvements in their governance arrangements. This was because some policies were out of date, audits were not robust and mandatory staff training, supervision, and appraisal rates were lower than the hospital target. At this inspection, we found that managers took action throughout the year to improve the governance arrangements at the hospital. Most of these issues were resolved at the time of our inspection. Managers reviewed all out of date policies and communicated new and amended policies to staff. We saw that the hospital had an effective governance structure and systems in place to make improvements in the service. However, the hospital had not made sufficient improvements that provided assurance about the safety of patients. This was in relation to staff compliance with

hospital policies and procedures for rapid tranquillisation and staff compliance with mandatory life support training. The hospital did not have a policy that fully demonstrated how staff supported patients who smoked because it only referred to patients who smoked in their own home. The observation protocol did not refer to corridor observations and did not fully support staff who carried out observations with patients to keep them safe.

Maintaining sufficient and adequate staffing levels to meet patient needs remained a daily challenge for the service. All three wards had adequate administrative support and managers were well aware of the staffing issues. They took appropriate action to attract, recruit and retain qualified nurses and support workers. Managers aimed to improve staffing levels and launched a recruitment campaign. The hospital had successfully recruited some staff and continued with their recruitment efforts. Managers consulted with staff and reviewed staff working conditions and pay to encourage retention of their staff. Managers recruited more senior rehabilitation support workers and introduced shift co-coordinator roles to support qualified nurses. The reduced occupancy levels reflected the staffing situation against the needs and observation levels of individual patients.

However, the use of agency staff remained high and managers took action to reduce the impact of unfamiliar staff on patients and regular staff. This involved offering regular contracts to agency staff who performed well. Where incidents occurred that involved agency staff such as medication errors, managers worked closely with the agency to ensure immediate actions and investigations occurred. The service did not report a high number of incidents associated with the use of agency staff and patients and their families did not report any significant impact. Most staff we spoke with felt staffing issues could be improved.

The service held a local risk register that included risk identified as high, medium, or low level. Managers identified the recruitment and retention of staff as medium risk and documented the control measures they used to manage the risk.

Leadership, morale and staff engagement

Since our previous inspection in February 2016, the senior management team had changed and included clinical and non-clinical staff. The lead nurse and all three senior staff nurses held developmental posts and were included in the management team structure. Managers were clear about their roles and responsibilities but also worked closely together on shared issues. Some post holders were new and some staff we spoke with were less clear about the roles and responsibilities of senior managers.

Since our inspection in February 2016, managers had engaged with the Care Quality Commission and provided on-going information about the service and progress with improvements. In preparation for this inspection, managers engaged with staff and produced an informative guide to prepare them for the inspection. This included information about the planned focus groups and prompts for staff about important issues such as infection prevention and control, safeguarding and Duty of Candour. It recognised achievements since the last inspection and continuous improvement work. All staff had access to the guide and we saw printed examples in staff areas.

Managers used key performance indicators to gauge the performance of staff about numbers of staff, hours, sickness, and appraisals.

All three wards had one clinical lead and one senior staff nurse on each ward. Two clinical leads were psychologists and one was an occupational therapist. All worked directly with aspects of clinical care and included administrative and managerial responsibilities. They were not routinely counted in the ward establishment and staff told us they were less likely to spend time “on the floor”. Qualified nurses, rehabilitation support workers, and senior rehabilitation support workers spent the most time engaged in direct patient care. They were also involved in staff supervision, appraisal, and shift co-ordination. There was a clear demarcation of roles at York House with staff describing themselves as “floor staff” and “therapy or clinical staff”. Some “floor” staff felt their views about patient care were not always listened to by clinical staff.

Managers were reviewing job descriptions for clinical staff and the shift system for ward staff. Managers had consulted with staff during this process and considered their views. The hospital had appointed a number of senior staff into developmental roles since our previous inspection. Senior managers supported staff with their leadership development with in-house management training and supervision.

Good

Services for people with acquired brain injury

Morale amongst staff was mixed and the negative feedback we received was associated with working conditions, changes to shift patterns, concerns about staffing and communication between "floor" and "clinical" staff. Two staff felt that managers did not consider their views and get the best from staff. However, most staff told us they enjoyed their work and we received positive feedback about how supportive managers had been for some staff. No staff we spoke with reported any incidences of bullying or harassment. All staff felt confident about whistleblowing and raised concerns without fear of victimisation. The results of the recent staff survey reflected that the majority of staff were happy with their job. Managers had analysed the results of the survey further and identified and took action to make improvements based on staff responses.

The hospital had not completed their workforce race equality standard review but had commenced an action plan to address this. These standards apply to independent hospitals when National Health Service contracts with the hospital are at least £200,000. It requires managers to consider staff equality and diversity, to ensure that employees from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Managers recognised that it was beneficial to have a diverse workforce and provide equal opportunities to all people without discrimination and carried out an initial review of the standards and an action plan. The hospital had an up to date equality and diversity policy and procedure and widened their range of advertising for staff recruitment to gain a greater range of candidates. All employees completed a mandatory equality and diversity awareness module on the first day of their induction. The manager told us that plans for the information technology system at the hospital included new systems to collect information about staff demographics.

Commitment to quality improvement and innovation

York House did not participate in any national accreditation schemes. However, the service was committed to making improvements and had involvement in research. The development of the integrated model of care led by the neuro psychologist aimed to improve patients' experiences of their care and treatment. York House hosted an annual seminar with their peers in October 2016. Staff shared information about the model and the training and development programme to support staff.

York House took part in a range of local and nationwide disabilities trust audits. Because of their work, they were able to demonstrate where they had made changes to improve the outcomes and experiences for their patients. Managers identified priorities for the coming 12 months to improve service standards and delivery such as internal auditing and incident reporting.

York House had a property strategy to improve the environment and ensure it was fit for purpose and met the needs of their patients. This included both short-term and long-term plans for the building. All staff groups we spoke with identified that improvements in the building and the environment were important for patients care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that staff adhere to the hospital polices related to medicines management.
- The hospital must ensure that all mandatory training meets the hospital compliance target.

Action the provider SHOULD take to improve

- The hospital should ensure that all staff comply with infection prevention and control measures.
- The hospital should review staffing to ensure there are sufficient and adequately trained staff to support patient activities and therapies.
- The hospital should review the incident reporting system to include documentation related to the level of harm sustained because of the incident.
- The hospital should ensure that patient's dignity and confidentiality is maintained. This includes ensuring that all bedroom windows have privacy screening and information held on visual display boards is confidential.
- The hospital should review the supervision and appraisal arrangements for bank staff.
- The hospital should review the effectiveness of communication including discussions at multi-disciplinary meetings and information at handovers.
- The hospital should ensure they comply with the requirements for the Workforce Race Equality Standards.
- The hospital should review the observation protocol and smoking policy to ensure that those policies fully support staff and patients at York House.

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 hospital must ensure that staff are up to date with life support training.** **This is a breach of Regulation 12 (1), (2) (c)**

This section is primarily information for the provider

Enforcement actions

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 Staff must adhere to the hospital policy in relation to physical health monitoring following the administration of medication for rapid tranquillisation. We served a warning notice about the continued breach of Regulation 12 Safe Care and Treatment 12 (1), (2) (g) which the hospital must meet by 19 June 2017.