# 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** | **Requires improvement** |
| Are services safe? | **Requires improvement** |
| Are services effective? | **Requires improvement** |
| Are services caring? | **Good** |
| Are services responsive? | **Requires improvement** |
| Are services well-led? | **Requires improvement** |

### 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 requires improvement because:

- Staff members were not all up to date with their mandatory training, annual performance appraisal or supervision.
- Staff vacancies and a high level of one to one observation meant high use of regular bank and agency staff, especially at weekends. Fifty one nursing shifts had not been covered in a three month period. Staff and carers told us this adversely affected consistency of care, safety and communication.
- Staff had recorded that the fridge used to store medication on Moors ward was operating outside of the normal range on 53 occasions during the two months prior to our inspection. This meant we could not be sure medicines stored in this fridge were safe to use.
- A policy on rapid tranquilisation was in accordance with national guidance. However, staff had not always made observations following administration of rapid tranquilisation nor recorded them as set out in the policy.
- The provider carried out regular medicines audits, however we found these were lacking in scope and detail. Staff had not documented clear actions in response to negative findings in audits from November 2015 and January 2016.
- Cleaning schedules did not demonstrate that staff cleaned all ward areas regularly or checked them for cleanliness.
- The hospital had not adjusted policies and procedures to reflect the changes following the update to the Mental Health Act code of practice in April 2015.
- Staff did not routinely offer patients copies of their care plans.
- The provider did not have a locked door policy.
- The hospital had an insufficient number of dedicated rooms available for staff to have one-to-one interventions with patients. This might sometimes compromise privacy, dignity and confidentiality.

However:

- Managers had been through a consultation process with the staff team to make changes to the shift pattern. It was envisaged this would improve communication, consistency of care and improve the patient experience. The new rota had been completed and was due to start 28 February 2016.
- The patient group had complex physical healthcare needs. The GP attended the service for two sessions each week. In addition to this, the hospital employed two registered general nurses to support the delivery of physical interventions.
- Comprehensive assessments were completed prior to admission by a psychologist and a registered nurse. This allowed for equipment and facilities to be made available on admission.
- There was an extensive multi-disciplinary team who worked well together to provide a wide range of quality treatment options within a model of care specifically designed for the patient group.
- We saw high levels of engagement and involvement of patients in a variety of settings.
- Staff spoke to patients in a way that was respectful, clear and simple. Staff allowed patients time to think things through and did not rush patients to give an answer to questions.
- Carers groups were held at weekends to support attendance of those who work or have a long way to travel.
- There were 19 patients discharged from the service in 2015. These were to a variety of settings such as returning home, care homes, another rehabilitation centre and supported living homes.
- Patients had personalised their bedrooms with photos, posters and electronic equipment such as televisions, games consoles and music players.
- Team working was evident across the hospital. There was a strong team ethos and we heard and saw how staff prioritised patient care.

# Summary of findings

- Recruitment procedures were thorough and abided by both the York House recruitment policy and employer's legal obligations.
- Senior managers made regular visits to the hospital and were known by staff and patients.

# Summary of findings

## Contents

Requires improvement

# 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. York House forms part of a partnership between the Disabilities Trust and The Retreat based in York.

The hospital had a registered manager and accountable officer in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 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 CQC since 02 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, and (4) treatment of disease, disorder or injury.

The hospital has been inspected by the CQC on three previous occasions. The last inspection on 23 October 2013 found no breaches of regulation and the service is currently deemed as compliant as of 22 November 2013.

## Our inspection team

Team leader: Janet Dodsworth, Care Quality Commission

The team that inspected the service comprised of three CQC inspectors, a CQC Mental Health Act reviewer, two CQC pharmacists a CQC assistant inspector and four specialist advisers: an occupational therapist, a psychiatrist, a registered general nurse and a registered learning disability nurse.

## Why we carried out this inspection

We inspected this service as part of our ongoing 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 location, received feedback on the provider from commissioners, the local safeguarding team and advocacy services.

During the inspection visit, the inspection team:

# Summary of this inspection

- Visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff cared for patients.
- Spoke with 15 patients who were using the service.
- Attended a carers group with three carers and a person who had been discharged from the service in 2015. We spoke with three carers by phone and met with two during our visit.
- Attended and observed two hand-over meetings, one multi-disciplinary meeting and a care programme approach meeting.
- Attended a service user forum and a music group.
- Collected feedback from one patient using a comment card.
- Looked at 16 care and treatment records of patients.
- Spoke with the divisional manager, service manager, consultant psychiatrist, consultant psychologist, clinical lead and a senior nurse.
- Spoke with 23 other staff members; including, assistant psychologist, registered nurses, student nurse, rehabilitation support workers, occupational therapist, social worker; speech and language therapist, physiotherapist, therapy assistants, housekeeper, safeguarding and MHA lead, a member of the maintenance team, pharmacist, HR manager and rota co-ordinator.
- Held four focus groups for a wide range of staff members, this included seven registered nurses, two student nurses, nine allied professionals, ten rehabilitation support workers and ten staff from administration, maintenance and housekeeping.
- Spoke with an independent advocate.
- Carried out a specific check of the medication management on all wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the service say

We attended a carers group which was held at the weekend to support attendance. Relatives of two patients who had been discharged attended. We also met with the parents of an existing patient and spoke with three carers by phone. Feedback about the service was very positive. All carers commented that the service had offered specialist care and treatment.

Patients made positive comments about staff. They told us that staff were caring and took time to speak with them. They told us that staff respect their personal space and always knock on bedroom doors and wait to be invited in. Patients told us they could choose from a wide range of activities and staff members were proactive in making this happen wherever possible. Patients enjoyed playing pool and spending time in the café area provided in the hospital next door. They felt the hospital would benefit from more communal space within its own building.

# 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;

- Mandatory training for permanent and bank staff was below 75% in a number of areas.
- The cleaning schedule did not demonstrate that the hospital was cleaned and checked for cleanliness.
- The provider did not have a locked door policy.
- There was a policy in place for rapid tranquilisation which was in accordance with national guidance. However, we found observations following administration of rapid tranquilisation had not always been undertaken and recorded as set out in the policy.
- Staff vacancies and one to one observation meant high use of mostly regular bank and agency staff, especially at weekends. There were 51 support worker shifts that had not been covered in a three month period. Staff and carers told us this impacted on consistency of care, safety and communication.
- The fridge used to store medication on Moors ward had been recorded as operating outside of the normal range on 53 occasions during the previous 2 months. This meant we could not be sure medicines stored in this fridge had been safe to use.
- The provider carried out regular medicines audits, however we found these were lacking in scope and detail. Clear actions had not been documented in response to negative findings in audits from November 2015 and January 2016.

However:

- In recognition of some of the staffing difficulties, especially around weekends, the hospital had recently been in consultation with the staff team to make changes to the shift pattern. The provider has started recruitment of an additional three registered nurses and 10 extra rehabilitation support workers to help cover annual leave entitlement. It was not clear when the new staff will be available to start. The new rota was due to start on the 28th February 2016. The management team envisaged the new rota will improve communication, consistency of care and improve the patient experience.
- Some patients had complex physical health needs. The GP attended the hospital for two half days each week. In addition to this, the hospital employed two registered general nurses to support the delivery of physical interventions.

# Summary of this inspection

- Emergency equipment was readily available to all three wards and there was a procedure in place to ensure this was fit for use.
- Staff had a good understanding of safeguarding procedures.

## Are services effective?

**Requires improvement**

We rated effective as requires improvement because:

- The provider advised us that 69% of contracted staff and 50% of bank staff had completed training in the Mental Health Act. This did not include training on the changes to the code of practice made in April 2015. The Mental Health Act lead advised us that they had provided registered nurses with a paper update of the changes within the Code of Practice. However we asked registered nurses if they were aware of the changes and they were not able to demonstrate this.
- The Mental Capacity Act policy was due for review in September 2015, so this was out of date.
- Staff performance, appraisal and supervision had not completed within the timescales set out within York House policy. This meant that some staff members were not regularly having their performance appraised or having ongoing supervision to ensure they were performing their role to the required standard.

However:

- The service used the neurobehavioural programme (NBP) which is a recognised long term treatment for individuals who had sustained an acquired brain injury (ABI) and had been unsuccessful living in the community or in other facilities.
- Comprehensive assessments were completed prior to admission by a psychologist and a registered nurse. This allowed for equipment and facilities to be made available on admission.
- A range of recognised outcome measure tools were in use to support and direct treatment and care options.
- Staff described good working relationships between teams. We received feedback from advocacy, the local safeguarding team and a commissioner of the service who all described good working relationships with the hospital.
- Multi-disciplinary team meetings were held each week and we observed how patients care and treatment was discussed thoroughly, taking into account the views of the whole team, the patient and their family.
- Care plans were mostly up to date, comprehensive and individualised to the needs of each patient.

# Summary of this inspection

## Are services caring?

Good

We rated caring as good because;

- Staff spoke to patients in a way that was respectful, clear and simple. Staff allowed patients time to think things through and did not rush patients to give an answer to questions.
- We saw high levels of engagement and involvement of patients in a variety of settings.
- Advocacy made weekly visits to the hospital and commented on the staff team always supporting requests to meet with patients.
- Care plans were individualised for the specific needs of each patient. We saw how community involvement was a large part of the therapy programme.
- Carers groups were held at weekends to support attendance of those who work or have a long way to travel.
- Relatives described the staff team as skilled to deal with challenging situations such as when patients became frustrated and had difficulty in making their needs known.

However

- There was no evidence that patients were given copies of their care plans.
- Two carers made negative comments about the use of bank staff on weekends and how this had a negative impact on the way staff were able to communicate with patients and meet their needs.

## Are services responsive?

Requires improvement

We rated responsive as requires improvement because;

- Staff told us they often had to use communal areas or bedrooms to meet with patients for one to one interventions as there were limited facilities available for this. This did mean rooms were not always available for the purpose they were intended, restricting the use for other patients and impacting on the privacy and dignity of patients.
- The recorded temperature on Dales ward was below 18 degrees in some areas. There was no system for recording temperatures and taking appropriate action when outside of 19-24 degrees. This temperature is recommended in a report commissioned by NHS estates, which states the temperature for circulation spaces / hospital wards should be 19-24 degrees centigrade.
- The complaints policy was due for review in November 2015 this means it was out of date.

However:

# Summary of this inspection

- There were 19 discharges from the service in 2015. These were to a variety of settings such as returning home, care homes, another rehabilitation centre and supported living homes.
- Patients had their bedrooms personalised with photos, posters and electronic equipment such as televisions, games consoles and music players.
- Staff supported patient on regular trips into the community to undertake a variety of activities for example, a short holiday, fishing, shopping, church services, horse riding and slimming classes.
- Staff members used several different methods to communicate with patients with communication difficulties. Some staff used simple Makaton language to communicate and there were posters on ward to support this. Some patient used digital iPad's that respond to eye movements. Patients had access to large print books and easy read format documents.
- Visitors told us they get chance to visit bedroom areas when appropriate. There were rooms available for visits during the weekend when they were not required for group activities. There was also a family visiting room available at a local hospital which could be booked in advance. The family room was always used when children visited.

## Are services well-led?

**Requires improvement**

We rated well led as requires improvement because:

- At the time of the inspection there were several senior positions vacant, this included two senior staff nurses and head of care. In addition, there were two long term absences by members of the senior management team. One of these positions had been filled temporarily and workload had been distributed amongst other senior staff members. We saw how this had impacted on effective communication, audit procedures and staff morale. Some staff described not receiving information about important changes, especially about the recent changes to the senior management team arrangements and not feeling up to date.
- The standard for overall compliance with mandatory training and refresher training set by the organisation was 100%. For permanent staff, compliance was overall average 74% with many areas recorded below 75%. Bank staff mandatory training compliance was below 80% in all areas. This meant that staff members were not systematically kept updated with their training.

# Summary of this inspection

- Policy stated staff should receive a performance appraisal each year. Only 66% of care staff and 47% of other staff had received an annual performance appraisal. This meant there was no structured way to ensure staff maintained the necessary skills to meet the needs of the people they care for and support.
- There were five policies due for review that were out of date.

.However:

- In recognition of some of the staffing difficulties, especially around weekends, the management had been in consultation with the staff team to make changes to the shift pattern. It was envisaged the changes would improve communication, consistency of care and improve the patient experience.
- Recruitment procedures were thorough and abided by both the York House recruitment policy and employer's legal obligations.
- Team working was evident across the hospital. There was a strong team ethos and we heard and saw how staff prioritised patient care.
- Senior members of the team were accessible and known to staff members.
- Improvements had been made to governance systems to ensure that results from audits were collated into a quality inspection audit tool for discussion at monthly governance meetings.

# 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.

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients and completed a mental health act monitoring visit on one ward.

Records showed 69% of contracted staff and 50% of bank staff had completed MHA training. The Mental Health Act lead had provided registered nurses with an update of the changes within the Code of Practice in April 2015. However, the MHA training had not been updated to reflect the changes and registered nurses told us they were not aware of the changes. We were told that all MHA guidance, policies and procedures were being updated by the provider. The deadline for completion was February 2016. They had not been completed at the time of our visit. A copy of the MHA Code of Practice was available on wards.

The provider had a MHA lead and administrator who completed audits and scrutinised documents. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing and medical staff in meeting the responsibilities of the Act.

Staff informed patients of their rights verbally and in writing. Staff told us, that if required, this could be provided in easy read format. Support was also available through the speech and language therapist for those with communication difficulties.

Evidence that patients were given information on their rights to appeal was available. We found that this included a record of how the patient responded and their understanding.

The provider had access to an independent mental health advocacy (IMHA) service with all patients able to access this. Patients confirmed they were aware of this service and records indicated who the IMHA was for each patient.

We found there was a standardised process in place for authorising section 17 leave. Section 17 leave forms were clearly written.

We found the provider did not have a “locked door” policy. We saw all wards were accessed through locked doors and it was unclear what process was in place to review of monitor this restriction.

## Mental Capacity Act and Deprivation of Liberty Safeguards

During the inspection, we looked at 16 inpatient care records across all three wards, looking closely at compliance and understanding of the Mental Capacity Act (2005) (MCA).

Training records showed that 74% of contracted staff and 52% of bank staff had completed MCA training. Records showed that capacity to consent and to make specific decisions was recorded appropriately.

There was a MCA policy however this was due for review in September 2015 so this was out of date.

There were 10 patients with Deprivation of Liberty Safeguards (DOLs) in place, and five pending applications. For those patients with DOLs, we saw that paperwork was present, well completed and applications made in a timely and appropriate manner.

There was a MCA and Safeguarding lead, and staff sought advice when they needed to. This person also audited MCA assessments and process and attended weekly multi-disciplinary team meetings to ensure that decisions made were compliant with MCA.

Requires improvement

# Services for people with acquired brain injury

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

## Are services for people with acquired brain injury safe?

Requires improvement

### Safe and clean environment

The hospital appeared to be clean and well maintained however, there were large gaps in the cleaning schedule documentation. Whilst the bedroom we viewed appeared clean, the system in place did not ensure that all areas were cleaned and checked for cleanliness. There had been shortages in the regular housekeeping team over the past six months and other staff had supported during this time on an ad-hoc basis. Rehabilitation support workers also helped patients to clean their own rooms as part of the ongoing rehabilitation where this was possible. Records documenting this were kept, but these were not up to date or fully completed. On the first day of inspection we noted a strong smell of urine in the lounge on Wolds ward. The sofa cushion was wet and the communal toilet on the corridor was dirty. We made staff aware and this was attended to immediately.

Members of the multi-disciplinary team (MDT) told us they did not have personal alarms to use when working on wards or in one to one sessions with patients. We asked the manager about this and they were not aware of the shortfall. Alarms were immediately ordered for all staff to have whilst working in one to one sessions with patients. Most rooms on the unit had room alarms but we noted the activity room did not.

There were environmental risk assessments for all areas. These detailed any potential ligature points, potential fire risks, lighting, disabled access, cleanliness and waste. This supported staff to identify which patients could be accommodated in which room depending on their individual needs and risks. There were details of how risks for each patient would be mitigated, for example, one patient had a seizure monitoring alarm to alert staff. The manager told us that patients with a high risk of suicide, and in particular by ligaturing would not be accepted into the service.

Clinic rooms were clean and there was equipment available to manage the complex physical health of the patient group. However rooms were small and mainly used for the storage, preparation and administration of medication.

Emergency equipment was readily available to all three wards and there was a procedure in place to ensure this was fit for use. Adrenaline was stored for emergency use but staff had not completed a risk assessment with regard to the provision of emergency medicines. We were told staff would dial the emergency services in any emergency situation.

The Dales and Wolds wards were for male patients only. The Moors had both male and female patients. Male and female bedrooms were on separate corridors. All bedrooms were en suite with toilets and showers. There was a bathroom which was located on a communal corridor, this was equipped with specialist equipment to support patients with mobility restrictions. There was a separate room which could be used as a female lounge if required.

Hand washing facilities and disinfecting hand gels were available on all wards and we observed these being used routinely by staff during our inspection.

### Safe staffing

Requires improvement

# Services for people with acquired brain injury

Clinical staff not included in the nursing establishments were reported as:

Lead nurse 1WTE (Whole Time Equivalent).

Consultant psychiatrist .8 WTE.

Consultant clinical psychologist 1 WTE.

Clinical psychologist 2 WTE.

Assistant psychologist 3WTE

Speech and language therapist 1.8WTE.

Occupational therapist 3 WTE.

Physiotherapist 1.8WTE.

Social worker .8WTE.

External dietician 10 hours per week.

Senior staff nurses 3 WTE.

Therapy assistants 4WTE.

Ward based nursing staff:

**Dales ward**

Staffing establishment qualified nurses 8.5.

Staffing establishment rehabilitation support workers (RSW) 19.6.

Number of vacancies qualified nurses 0.

Number of vacancies RSW 0.

Number of shifts filled by bank or agency to cover sickness, absence or vacancies November 2015 – January 2016 - 359.

Number of shifts that had not been filled by bank or agency to cover sickness, absence or vacancies. November 2015 – January 2016 – 27.

**Moors ward**

Staffing establishment qualified nurses 8.

Staffing establishment rehabilitation support workers (RSW)18.6.

Number of vacancies qualified nurses 1.

Number of vacancies RSW 0.

Number of shifts filled by bank or agency to cover sickness, absence or vacancies November 2015 – January 2016 – 324.

Number of shifts have not been filled by bank or agency to cover sickness, absence or vacancies November 2015 – January 2016 – 24.

**Wolds ward**

Staffing establishment qualified nurses 4.6.

Staffing establishment rehabilitation support workers (RSW)15.4.

Number of vacancies qualified nurses 0.

Number of vacancies RSW 0.

Number of shifts filled by bank or agency to cover sickness, absence or vacancies November2015 – January 2016 – 157.

Number of shifts have not been filled by bank or agency to cover sickness, absence or vacancies November 2015 – January 2016 – 16.

Staff sickness for qualified nurses and RSW in the last 12 months was 5.6% (1.4% represents long term sickness) Staff turnover for qualified nurses and RSW in the last 12 months is 17.3%.

There was only one nursing vacancy highlighted but a high number of shifts (840) had been covered by bank or agency and we asked the manager why this was the case. We were told that nursing establishments are calculated based on the number of available beds, using a tool provided by the Disabilities Trust. The ratio of nursing staff to patients is one staff member for every two patients during the day time and three staff members in total per ward at night. There are regularly a large percentage of patients requiring one to one observations, to support their physical health conditions and the impulsivity of challenging behaviours with the possibility of assaulting other patients. There would be one extra staff member for every patient on one to one observations, day and night.

The allowance built into the nursing establishments for constant observations, annual leave, sickness or training was not adequate. This meant that overtime, bank and agency staff backfilled these shifts. On weekdays additional support was also available from other members of the wider multi-disciplinary team.

We noticed high levels of bank and agency used at weekends and we were told this was to allow permanent staff to have alternative weekends off. The bank consists of 52 staff members, some work regular shifts. The same

agency is used on a regular basis and provides the same staff to cover shifts. There was no support from the wider team at weekends and due to senior staff shortages there was not always a senior staff member in the hospital.

The management had just been through a long consultation process with the staff team and was currently changing the shift pattern. Management envisaged the changes would improve communication, staff welfare, consistency of care, the patient experience and also reduce staffing costs. We were told the provider was looking to recruit additional three registered nurses and 10 rehabilitation support workers. This would allow for more annual leave cover by permanent staff members. This recruitment had only just started and would not be in place when the new rota started on 28 February 2016.

Each ward had at least one qualified nurse on shift at all times. Monday to Friday, this was further enhanced by three senior nurses and a physical health nurse who were not included in the nursing establishments. On weekends the senior nurses and lead nurse worked on a four weekly rota to provide leadership on site. Due to staff leaving the service, there was only one senior staff nurse so this was not the case during the inspection. There was however always a senior member of the team on call plus an on call doctor if required.

Some patients had complex physical health needs. The GP attended the hospital for two half days each week. In addition to this, the hospital employed two registered general nurses to support the delivery of physical interventions.

There was no treatment room where all medical equipment could be stored and physical examinations undertaken, there was no examination couch in any of the clinical rooms. Physical examinations were often undertaken in the patient's bedrooms. Whilst this might not always be the best option, due to the intimate nature of some examinations, nurses commented that patients were more relaxed in their own rooms. Nurses felt a treatment room would enhance the delivery of physical health interventions and the co-ordination of physical care.

There was a consultant psychiatrist who specialises in neurobehavioural treatment who worked 30 hours per week. We saw confirmation of revalidation and annual appraisal for the psychiatrist. A psychiatrist was always available on call day and night and the hospital shared a rota with the local hospital next door to provide this.

The aspirational standard for the completion and refreshing of mandatory training set by the hospital was 100%. The overall average for permanent staff was 74% with several areas below 75%: defensible documentation 68%, Mental Capacity Act 65%, Mental Health Act 74%, nutrition 66%, food hygiene 62%, emergency life support 68%, immediate life support 68%. The overall average for bank staff was less than 75% in all areas with the exception of breakaway training at 76%. This meant that not all staff members were receiving the necessary mandatory training and refresher training to undertake the requirements of their role.

**Assessing and managing risk to patients and staff**

There were two trainers, employed by York House to deliver annual training in the Prevention and Management of Violence and Aggression (PMVA). The course was four days and covered a range of de-escalation techniques as well as the physical aspects of restraint. Training for PMVA was 94% for permanent staff and bank staff 61%. Staff described how trainers would come to the wards when they needed support with patients in situations that were unique due to some of their physical disabilities. We saw how staff discussed different ways to support patients and incorporated this into care plans. Trainers also attended wards and were available to help staff to reflect on situations and adapt their approach if required.

Recorded incidents of restraint in the last six months to end January 2016; Dales -48 incidents involving five patients, Moors- 21 incidents involving four patients and Wolds -seven incidents involving three patients. Staff reviewed Incidents of restraint in weekly multi-disciplinary team meetings making adjustments to approaches and updated management plans.

There was no use of prone restraint (where the patient is restrained faced downwards) and no episodes of seclusion recorded. The hospital did not practice seclusion and there was no seclusion room. During the inspection we observed several occasions where staff used de-escalation techniques to defuse situations and avoid any physical contact.

Requires improvement

# Services for people with acquired brain injury

We viewed 13 risk assessments which were present and up to date with the exception of one which was out of date. The risk assessment used for patients was a brain injury rehabilitation trust matrix (BIRT Risk Matrix) developed by the clinical executive team specifically for those with an acquired brain injury. We attended the multi-disciplinary team meeting and saw risk assessments for four patients fully reviewed by the team to provide a fully integrated approach to risk and support plans. We saw from meeting records that this happened at every multi-disciplinary team meeting which reviewed each patient on a five weekly rotation.

There were very few restrictions on the wards. We did notice that there was limited access to hot and cold drinks for some patients. There was a water fountain on the corridor of each ward but no cups. We were told this was to support patients with brain injury who are not able to manage their fluid intake. Excess drinking can cause physical health problems which can prove fatal. Some patients were risk assessed to have a fob for entry to the kitchen area, where they could make drinks. We saw how other patients without the ability to manage their own fluid intake or manage safely in the kitchen area were offered drinks at regular intervals. There was a notice on the kitchen door advising patients to ask a staff member if they wanted a drink.

Exit from the hospital was through locked double doors acting as an airlock. There was no locked door policy and patients could not access outside space without staff assistance. There was a small notice for informal patients telling them to speak to the doctor should they wish to leave. We raised concern regarding the size and content of this notice. It was replaced during our visit with a larger poster which was easier to read. None of the patients raised this as an issue and we saw frequent escorted access to outside space throughout our inspection.

On Dales ward there were high levels of one to one observations and we were advised that routinely this can be six or more patients. There was an observation policy which allowed for some flexibility depending on the reason for the observations. For example where this was to prevent patient to patient assault, patients could be allowed private time in their bedrooms with staff waiting outside and checking on the patient at pre-determined times. Bedroom doors were solid with only one anti barricade door (doors that open both inwards and outwards). The majority of doors had no ability to see into the room but some had a spyhole giving a restricted view. We were concerned that patients might fall behind the door making access difficult.

A policy was in place for rapid tranquilisation which was in accordance with national guidance. However, in the three months prior to the inspection we found observations following administration of rapid tranquilisation had not always been undertaken on two occasions or recorded as set out in the policy. This could leave patient at risk of physical health issues, for example cardiac arrest.

Staff had an understanding of safeguarding procedures and knew how to raise concerns. Training figures were 73% for permanent staff and 48% for bank staff. There was a safeguarding lead and a safeguarding policy. The safeguarding lead described how they used an agreement with the local safeguarding team to identify levels of risk. Any low level incidents are dealt with in house. If they are in any doubt they will contact the local safeguarding team for advice. Any concerns that relate to staff members would automatically get referred. The quality assurance team and divisional manager had oversight of all referrals. The safeguarding lead described the relationship with the local safeguarding team as good. They attended local implementation meetings and they had a working group for the Care Act before it became a statutory requirement. We spoke with the safeguarding team at the local council who confirmed that the hospital responded well to any concerns which were handled appropriately.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. On Moors ward records showed medication fridge temperatures had been outside the normal range on 23 occasions in December and on 30 occasions in January and no action had been taken or documented in the temperature records. This meant we could not be sure that medicines stored in this fridge had been safe to use during this two month period. The temperature was within range during the month of February and on the day of our inspection.

There was a clinical pharmacy service for all three wards; pharmacy staff checked patients' medicines on admission to wards and carried out regular checks on prescriptions to ensure they were safe and compliant with the Mental Health Act.

Requires improvement

# Services for people with acquired brain injury

We checked 21 sets of medication records and found nurses gave medication as prescribed and in accordance with the Mental Health Act. However, medicines records were not always clearly completed; we found a number of gaps in the records we reviewed with no reason recorded why medicines had not been given. All medicines charts included an agreed variance in the time of dosing to guide staff whether it was appropriate to delay doses. This might be if the patient was agitated or not able to take medication for any reason. Staff completed comprehensive care plans for patients who had difficulty in taking their medicines to ensure they received them in a safe and timely manner.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, managed, and recorded appropriately. We saw evidence of routine balance checks of controlled drugs.

Nurses carried out regular medicines audits, however we found these were lacking in scope and detail. Clear actions had not been documented in response to negative findings in audits from November 2015 and January 2016. Medication errors and incidents were recorded and reported through the trust governance arrangements; there were 60 incidents involving medicines in the period January 2015 to January 2016. Minutes of the quarterly drug and therapeutics group meetings did not demonstrate analysis of medication errors to determine trends or patterns, or shared learning from incidents to prevent future re-occurrence.

There was a visiting policy and guidelines for visiting times based around the therapy model. We heard from relatives how the hospital is flexible, taking into account travelling distance for some families. Children under the age of 18 could visit by arrangement. Staff would book the family room at the local hospital which adjoins York House.

**Track record on safety**

There were no reported serious incidents in the last year.

Following a serious incident in 2015 at another acquired brain injury hospital, a “safe room” was being developed which will be ligature free. The manager told us the room will be completed by the end of February 2016. The room will be used for any patients who develop any risks from ligaturing to support their safety prior to transfer to another more appropriate service. Patients would not be confined to the room, it would offer a safe place to sleep and have some private time.

**Reporting incidents and learning from when things go wrong**

Staff members were able to describe the incident reporting process and what they would report. Reporting was via a paper document which is placed onto a computer by admin staff and then sent to the divisional lead and quality assurance manager for consideration. We saw examples of how incidents had been reviewed and changes made, for example there was an incident using a mobile hoist to assist a patient into a bath. This has prompted the provider to purchase a ceiling hoist for this bathroom to avoid this happening again.

Staff explained that de-briefing after an incident can be problematic as the staff team work a variety of shifts. This meant getting staff together at the same time was difficult. The hospital is currently changing the shift pattern and hope this will improve.

York House produced a lessons learned bulletin. We saw a version dated January 2016 which was the 11th version. This listed details on service user involvement and deprivation of liberty safeguards. It had useful references and resource links but did not mention specific incidents and changes to practice. We saw how lessons learned were sometimes cascaded through handovers and in team meetings. It was not clear how the provider was assured that all staff received updates on lessons learned and some staff described not receiving information about important changes and not feeling up to date.

The duty of candour requirement was discussed in team meetings and we saw this listed within the minutes. Staff understood the basic principles of the requirement in particular the need to be open and transparent when things go wrong and to offer an apology. Relatives commented that staff members contacted with them when there are incidents on the wards that impacted on their family member.

**Are services for people with acquired brain injury effective?**
(for example, treatment is effective)

Requires improvement

# Services for people with acquired brain injury

Requires improvement

### Assessment of needs and planning of care

We looked at 16 treatment and care records of patients across the three wards.

The staff team assessed patients over a 12 week period following admission. During the assessment period, patients participated in a full range of clinical functional assessments through an individualised programme. We saw timetables for each individual listing a range of activities and structured one to one time with members of the multi-disciplinary team.

Care records showed that physical health needs were addressed on admission and throughout treatment. There were two general nurses at the hospital and a GP visiting for two sessions each week to help ensure this happens in a structured way. Care plans evidenced regular input from a range of professionals for example continence nurse, speech and language therapist, physiotherapist, optician and dentist. We saw how staff monitored patients with increased risk of physical ill health, for example regular blood tests, weight management, nutritional assessments, and monitoring of blood sugar levels. Physical health care plans were comprehensive, regularly updated and reviewed.

Care plans were mainly up to date, only one we viewed was not in date. They were comprehensive and personalised to the needs of the patient. We saw care plans to support the use of least restrictive practice, nutritional intake, personal care, physical health, violence and aggression, activities and falls prevention. We saw evidence of discharge planning documented in two care plans. We did however see other records of discussions with regard to most appropriate placement options and discharge in multi-disciplinary team meetings and care programme approach reviews.

All patient information was stored securely and kept in one place. This made It easy to access details regarding patients care and treatment.

### Best practice in treatment and care

Rehabilitation followed the neurobevioural programme (NBP) which was a recognised long term treatment for individuals who have sustained an acquired brain injury (ABI) and have been unsuccessful living in the community or in other facilities. The programme assisted patients in managing their behaviour appropriately by learning skills to maximise their independence and to improve their overall quality of life. The programme used initial and ongoing assessments with a multi-disciplinary team approach to prioritise and minimise behaviour that prevents patients from being able to access the community. The multi-disciplinary team works with the patient, their family or other significant people in their life to meet goals whilst incorporating the patient's cultural and spiritual beliefs.

The service used a range of assessment tools for example:

- Overt Aggression Rating Scale Modified for Neurobahvioural Rehabilitation (OAS_MNR) used to examines changes in levels of physical and verbal aggression.
- Supervision Rating Scale which describes levels of support required.
- Brain Injury Re-habilitation Trust (BIRT) Independent living scale used to record accommodation needs and engagement in activity
- Hospital Anxiety and Depression Scale (HADS) used to measure the emotional disorder following a brain injury
- Mayo Portland Adaptability Inventory-4 used to chart the degree of impairment after a brain insult.

We attended a multi-disciplinary team meeting and a care programme approach meeting where we saw the results of outcome measures being used to influence care and treatment options for patients. The York House Annual Report 2015 details all aspects of care delivery, outcomes, news and ongoing plans for the coming year.

We saw how National Institute for Health and Care Excellence guidelines were used for supporting medication regimes, therapy approaches, managing challenging behaviour and cognitive impairments. We saw how medications were offered in a range of options, tablet, liquid, patch with options for oral and injections and how options were discussed with patients. Therapy options included a graded approach to community integration through group outings and escorted activities which lead to unescorted leave when appropriate.

There were two speech and language therapists, a dietician and three occupational therapists who work closely with

the patients to ensure nutritional needs are met using a variety of options. This included adaptive cutlery, soft meal choices and one patient was successfully receiving nutrition through a percutaneous endoscopic gastrostomy (PEG) tube.

We saw a range of clinical audit tools used to monitor performance in different areas for example infection control, medicines management and maintenance of emergency equipment. We did find a lack of action planning and actions to rectify issues contained within some audits. Some items had remained on the audit for more than three months without analysis, detailed actions or deadlines for completion.

**Skilled staff to deliver care**

There was an extensive multi-disciplinary team at York House to provide a range of care and treatment: registered mental health nurses, learning disability nurses, general nurses, rehabilitation support workers, consultant psychiatrist, consultant clinical psychologist, clinical psychologist, assistant psychologist, therapy assistant, speech and language therapists, occupational therapist, physiotherapist and a social worker. They also had an external dietician providing 10 hours each week and a GP providing two half day sessions each week.

There was a comprehensive induction programme for all new starters over a two week period. The training captured elements of the care certificate, sessions with members of the multi-disciplinary team and training in the prevention and management of violence and aggression.

York House policy states that staff performance appraisals should be undertaken annually to enable managers to review staff competency and support ongoing development. The supervision policy stated that all staff will have a formal management supervision session every three months (quarterly) and in the fourth quarter supervision will be replaced by a performance appraisal. Records demonstrated that 93% of allied professionals, 66% care and support staff and 67% of other staff had appraisals in the last 12 months.

The supervision policy also stated that health professionals should undertake clinical supervision in line with relevant national guidance from professional regulators and/or professional bodies, and it is monitored and reviewed. We viewed the supervision register for all staff. There were large gaps in the recording of supervision across all staff groups during 2015; predominantly nursing and rehabilitations support workers. This had improved for January and February 2016 however we noted that at least five registered nurses had not received any supervision since July 2015. The Nursing and Midwifery standards for competence for registered nurses states that nurses must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and training. This meant that large numbers of staff were not regularly having their performance appraised or having ongoing supervision to ensure they were performing their role to the required standard. We were told that completion of appraisals and supervision had been delayed by the absence of some senior members of the team.

We saw one example of how poor performance had been addressed and a staff member had been dismissed in accordance with the disciplinary policy.

**Multi-disciplinary and inter-agency team work**

Multi-disciplinary team (MDT) meetings take place weekly and each patient was discussed on a five week rotation. There was also time at the end of each meeting for discussion of any other patients care as required. We attended an MDT meeting and found that the patients were discussed thoroughly, including risk assessments, care plans and outcome measures. This information was used to update care records as appropriate within the meeting. Patients were always invited to attend and a feedback form was completed to share with any who did not want to attend or were not able. A patient attended the meeting and was fully involved by the team in a way that he could understand and make a valid contribution to the discussion and goal setting. The advocate also attended on behalf of one patient who did not want to attend and took feedback to the patient after the meeting.

Handover takes place whenever there is a change of nursing team. We attended handover on Dales and Moors and looked at handover sheets on Wolds ward. The handovers we attended were thorough with each patient discussed in detail and activities and tasks for the day allocated. We viewed the handover sheets on Wolds ward from previous four weeks. These were not always fully completed and it was not evident from the sheets that all patients had been discussed and appropriate information

handed over. We were told that there was a weekend handover between medical staff at a local hospital who supplied out of hours doctor cover on a rotational basis. There were no minutes kept from this handover.

All staff members we spoke with described good working relationships between teams. We received feedback from advocacy, the local safeguarding team and a commissioner of the service who all described good working relationships with the hospital.

**Adherence to the MHA and the MHA Code of Practice**

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients and completed a mental health act monitoring visit on one ward.

Records showed 69% of contracted staff and 50% of bank staff had completed MHA training. The Mental Health Act lead had provided registered nurses with an update of the changes within the Code of Practice in April 2015. However, the MHA training had not been updated to reflect the changes and registered nurses told us they were not aware of the changes. The hospital had not completed adjusting its policies and procedures to reflect the changes. We were told that all MHA guidance, policies and procedures were being updated by the provider. The deadline for completion was February 2016, this had not been completed at the time of our visit.

A copy of the MHA Code of Practice was available on wards.

.The provider had a MHA lead and administrator who completed audits and scrutinised documents. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing and medical staff in meeting the responsibilities of the Act.

Completed consent to treatment forms were located with prescription charts. We saw referrals to second opinion appointed doctors (SOAD) were made appropriately. There was no discrepancy between medications being administered and medications authorised by the SOAD. A T3 is provided by a SOAD when a person who lacks the capacity to consent to medication remains on medication after the first three months. It is also used when a person who has capacity does not agree to take medication after the first three months. The Code of Practice states the responsible clinician (RC) must discuss this with the patient or record why they have not. There was evidence to support that this had been completed.

Staff informed patients of their rights verbally and in writing. Staff told us, that if required, this could be provided in easy read format. Support was also available through the speech and language therapist for those with communication difficulties. Patients were given information on their rights to appeal and we found that this included a record of how the patient responded and their understanding.

All patient's had access to independent mental health advocacy (IMHA) service. Patients confirmed they were aware of this service and records indicated who the IMHA was for each patient. The hospital had a system to refer patients who lacked capacity to this service. The IMHA service felt supported by staff and was given adequate notice to ensure attendance at meetings.

We found there was a standardised process in place for authorising section 17 leave. Section 17 leave forms were clearly written. During the inspection we found that one section 17 leave form remained in use after leave authorisation had ended. The patient had been on 27 periods of leave over a three week period without any staff recognising this. In the other 10 records only the current leave form was located in the section 17 leave folder. Registered nurses did not always sign to say that they had agreed the patient was fit to go on leave. This left it unclear if a pre-leave risk assessment had been completed at the time of leave occurring. Patients own view of leave was rarely recorded.

We found the provider did not have a "locked door" policy. We saw all wards were accessed through locked doors and it was unclear what process was in place to review of monitor this restriction. At the start of the inspection two of the wards where there were informal patients had no notice to let them know how they could leave. The notice was put in place immediately. None of the three wards had information on how detained patients could complain to the Care Quality Commission. This was rectified during the inspection.

**Good practice in applying the Mental Capacity Act 2005.**

Requires improvement

# Services for people with acquired brain injury

During the inspection, we looked at 16 inpatient care records across all three wards, looking closely at compliance and understanding of the Mental Capacity Act (2005) (MCA).

York House told us that 74% of contracted staff and 52% of bank staff had completed MCA training. Staff applied this to support patients to make complex decisions, using the best interests' process and involving families and other professionals as required. We also saw good practice of the five key principles of the Act during the inspection, for example, one patient required restraint during personal care and had a clear positive behavioural plan in place to do this in the least restrictive manner and only by using restraint where necessary.

There was a MCA policy however this was due for review in September 2015 so this was out of date.

There were 10 patients with Deprivation of Liberty Safeguards (DOLs) in place, and five pending applications. For those patients with DOLs, we saw that paperwork was present, well completed and applications made in a timely and appropriate manner. We reviewed records of three patients who were informal. York House and York City Council felt that two of these patients had capacity to consent to their care and treatment. The MCA lead told us that this was regularly reviewed to ensure that they were not being unlawfully deprived of their liberty.

Capacity to consent and to make specific decisions was recorded appropriately. York House use the two-stage assessment of capacity to do this, which was the most appropriate tool as stated in MCA guidance.

York House provided care for individuals who often have difficulty in communicating their needs and wishes. Care planning and the use of communication tools showed that staff had taken all practicable steps to support individuals to make decisions. Some capacity assessments were done on more than one occasion, to ensure patients had lots of opportunity to voice their opinion. There was good use of advocates and Independent Mental Capacity Advocates (IMHA). Those individuals protected by Deprivation of Liberty Safeguards (DOLs) had a relevant person's representative (RPR) clearly noted on their file.

There was a MCA and Safeguarding lead, sought advice when they needed to. This person also audited MCA assessments and process and attended weekly multi-disciplinary team meetings to ensure that decisions made were compliant with MCA.

## Are services for people with acquired brain injury caring?

Good

### Kindness, dignity, respect and support

We observed staff interaction with patients during one to one interventions and in group situations. Staff spoke to patients in a way that was respectful, clear and simple. Staff allowed patients time to think things through and did not rush patients to give an answer to questions. There was a genuine desire from all members of the staff team to give patients the best support they could. We saw how sometimes this was in very difficult circumstances where patients had restricted means of communication.

We saw how patients always seemed happy to see staff members and knew them all by their names, including the service manager and the divisional manager. Patient's comments about the staff were overall positive, describing them as: "lovely", "quite nice, got a good sense of humour", "nice people" and "good".

### The involvement of people in the care they receive

Advocacy service was provided through Cloverleaf Advocacy services. The advocate attended the hospital at least one day each week to visit patients. The advocate told us that staff at the hospital always accommodated requests to meet with patients.

We attended a patient forum "actions and ideas group". We saw how patients were encouraged to fully participate in a wide range of topics. Patients were fully involved in the decision making process and we saw where suggestions had been made for activities, these had been implemented. We also attended a music group which happens every week. Patients chose songs and together with the staff team, everyone sang along and seemed to be having a good time.

Care plans were individualised for the specific needs of each patient. We saw how community involvement was a

Requires improvement

# Services for people with acquired brain injury

large part of the therapy programme. Patients attended groups in the community for example one patient was attending slimming world to support a structured weight loss programme.

There was no evidence that patients were given copies of their care plans. Patients were encouraged to attend MDT meetings and we saw this in practice.

Some of the patients were able to get away on holiday in 2015. York House was able to rent an accessible cottage in Pickering. This gave some patients a chance of a holiday when otherwise they might not manage this due to financial constraints or disability. The provider also used the assessment process and evaluation of this trip to support the planning of future holidays for those patients who might not be able to ever manage this without assistance. Six other service users went on holiday to a number of locations: Paris, Scotland, Lake District, Centre Parks and Ireland and one service user attended the World Cup Rugby opening ceremony and two further events.

We attended a carers group which was held at the weekend to support attendance of those who work or have long distance to travel. Two parents of former patients attended the meeting and one former patient. Feedback about the hospital was very positive, both families felt the hospital had been able to care for their family member in a way that other mental health hospitals had not. They felt the model of care and the level of containment had attributed to supporting recovery. Both patients had been discharged from the service to supported living in the community.

We spoke with three carers by phone and another two family members in person during the inspection. They told us how they feel very involved in planning care and how staff members brought patients on home visits each month as the distance to travel had been difficult for the families. They also told us how patients were supported to access activities within the community including trip out to eat, fishing trips, swimming and a trip to a motor show. They reported how they had seen staff dealing with some very difficult situations when patients had become frustrated and upset. They described the staff team as skilled to deal with these situations and that they always behaved in a professional manner. There were comments made about the use of bank and agency staff on weekends and how they felt this had a negative impact on the delivery of care by staff who did not know the patients individual needs as well as regular staff members.

We heard how patients get involved in the recruitment of staff by providing questions or by taking part in the interview process.

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

Requires improvement

### Access and discharge

There were 58 referrals to the service in 2015 and these were screened prior to assessment. Factors such as dementia diagnosis or other medical complications that would make treatment at York House inappropriate reduced actual assessments to 33. Following assessment the service had 14 new admissions in 2015 and some individuals are still awaiting funding agreement.

Due to the specialist nature of the service there were a high number of out of area placements, 14 patients were from the Yorkshire and Humber area and the other 14 are from areas across the country including London and Northern Ireland.

The average occupancy levels in the last six months were Dales 82%, Moors 92% and Wolds 98%. Beds were always available when patients returned from leave. We were made aware of an instance where a patient was not able to return to the hospital after a period of leave however we were informed this was due to deterioration in the patients' mental health which could not be accommodated back at York House. This was being investigated as a complaint by the hospital at the request of the patients' family.

The service offered a continuum of support across the three wards. Dales was a male only ward for patients at the start of their treatment and offered assessment and active rehabilitation with a focus on reducing challenging behaviour. The average length of stay on Dales ward was eight months. Moors was also an assessment and treatment ward primarily for females but also had male patients and also offered longer term rehabilitation with a focus on quality of life. The average length of stay on Moors ward was five years. Wolds ward offered continuous rehabilitation and support for males with an acquired brain

injury who had achieved their highest level of function. Those patients in York House who still required levels of support to maintain rehabilitation gains within a specialist environment that offered treatment and containment were transferred to Wolds ward when it opened three years ago. The average length of stay of patients on Wolds ward was nine years. We saw that the multi disciplinary team reviewed these placements in care programme approach (CPA) reviews and other placements were considered.

In 2015, there were 19 patient discharged across all three wards: Dales 13, Moors four and Wolds two. There had been some delays in discharge: difficulty finding placements locally agreed upon by the patient, their family and the funding authority, waiting for a new facility to open and a delay in staff at the new placement receiving appropriate training.

Patients were discharged to a variety of placements including returning home, care homes, rehabilitation centre and supported living. We saw examples of how discharge was planned through multi-disciplinary team meetings and CPA reviews. This was done in a structured way with periods of leave and review to ensure suitable packages of care were in place to support patients as they moved on.

**The facilities promote recovery, comfort, dignity and confidentiality**

There was a clinic room on each ward however these were small on Wolds and Moors, mainly used for the storage, preparation and administration of medication. There was a larger clinic room on Dales ward but none of the rooms had an examination couch. Patients requiring physical examination were seen in their bedrooms.

Staff told us they often had to use communal areas or bedrooms to meet with patients for one to one interventions as there were limited facilities available for this. An example of this was meeting with patients in the lounge area but other patients would be using this space making it noisy and lacking in privacy. Throughout the inspection we saw examples of this, how staff members delivering interventions often saw patients in communal areas, lounges, dining rooms and the quiet room. Whilst rooms were designated for specific uses, we saw how they were required to be used as multi-function rooms. There were no spaces specifically designated as rooms for the delivery of private one to one meetings with any system of booking to ensure availability for use. This did mean rooms were not always available for the purpose they were intended, restricting the use for other patients.

There was a dedicated room for the physiotherapist to give treatment including equipment and a couch. The hospital also had use of facilities at the local hospital next door including a large café area with pool table and large screen TV and a gym. Staff supported patients to access these facilities on a regular basis. Staff and patients described how the hospital would benefit from more dedicated patient activity space within its own building.

All wards had access to a pay phone. On Dales ward this was located on the corridor near the exit. While there was a privacy hood it offered limited privacy. We saw there was no seat and we were told this was because a patient who was a wheelchair user often used the phone. We heard there was no restriction on patients using mobile phones or electronic devices to contact family and friends. Staff offered patient's the use of a cordless phone for private calls. Relatives told us they were able to speak with patients at any time.

York House is located within large grounds of a local hospital. Access to outside space did have limitations due to the locked doors. Many of the patients were on constant observations due to physical health issues and we saw lots of examples where staff escorted patients outside for activities, trips and smoking.

Patients who smoked had care plans to support this. Due to cognitive impairments from the acquired brain injury, patients often have short term memory problems. There were also a range of physical conditions impacted by excessive smoking. We saw how smoking had been discussed through MDT meetings, including options for smoking cessation and then assessed in the best interests of the patients. Some patients had dedicated smoking times to support their desire to smoke, linked in with their care and treatment. There was dedicated smoking area outside the hospital but there was no smoking shelter due to environmental restrictions of the listed building and its surroundings.

We did notice that there was limited access to hot and cold drinks for some patients. There was a water fountain on each ward but no cups. We were told this process was to support patients with brain injury who are not able to

manage their fluid intake due to cognitive impairments. Excess drinking can cause physical health problems which can prove fatal. Some patients were risk assessed to have a fob for entry to the kitchen area. We saw how other patients were offered drinks at regular intervals and some kept their own cups to use. There was a notice on the kitchen door advising patients to ask a staff member if they wanted a drink.

We noticed on Dales ward that it felt cold. We sampled temperatures in patient's bedroom and communal areas and some recorded at 18 degrees centigrade or lower. Some patients also reported feeling cold. A report commissioned by NHS estates, recommends the temperature for circulation spaces / hospital wards should be 19-24 degrees centigrade. We mentioned this to the provider who made arrangements for the maintenance team to check the boiler and they also arranged for the local heating engineers to come and check the system. There was no system in place to routinely check room temperatures. The manager told us a system would be put in place to monitor this for future action as necessary.

On Dales ward (which is on the ground floor), when a patient was showing us their bedroom, two individuals passed the window and looked in at us. We were concerned for patients dignity should they forget to close their curtains when undressing or undertaking personal care. We asked the provider about this and they made us aware that the patient likes to be able to look out of his window as he has a lovely view of the grounds. They ordered special film to be applied to the window which would allow for the patient to see out but not for those passing see into the room.

Patients had access to a lockable storage area for their possessions. Patients had open access to their bedrooms and they were offered room keys if they wanted them.

We saw records of room searches. Where these were undertaken, they were in accordance with policy and undertaken based on individual need.

We saw a wide range of activities being undertaken within the hospital and in the community. This included fishing trips, kayaking, horse riding, fish and chip night. Whilst some patients had high levels of physical disability, staff made adjustments to ensure as many patients as possible could participate in outside activities. We noticed how activities were at weekends were more ad-hoc and relied on drivers being available and sufficient staff being available to cover the wards.

Food was provided by the adjoining local hospital and delivered to wards on heated trolleys. Feedback from patients on the food was mixed. Six patients told us the food was good and they got good choice and portions, one patient told us the food did not taste good and other told us the portions were not big enough. The catering department provided food to accommodate varying dietary requirements including those with cultural and religious needs. . We saw minutes from the catering meeting which described how patients meet the chef to discuss nutrition, menu choices and any feedback about the provision of the catering. There are also food tasting events which allowed patients to choose foods that were proposed for the new menus. The most popular choices went into the menu for the following month.

Staff supported patients with their spiritual needs and there was a hospital chaplain available to see patients. Staff supported patients to attend religious ceremonies as required.

**Meeting the needs of all people who use the service**

There were a number of patients with physical disabilities. The building offered large corridors but doors to bedrooms were heavy and difficult to navigate from a wheelchair. Where patients used wheelchairs, staff offered assistance as doors did not open automatically. This could impact on independence.

Two bathrooms were fitted with ceiling hoists to assist disabled patients with mobilising for bathing. The bathroom on Dales ward relied on a mobile hoist to assist patient's mobilising and this had contributed to an incident when the bath had moved and caused injury to a member of staff. This had been reviewed by the manager and a ceiling hoist was due to be purchased.

We saw the ward had information for patients and it included advocacy information and information about contacting the Care Quality Commission. There was also information on local activities for example banking hours and breakfast club.

We saw staff members using several different methods to communicate with patients with communication

Requires improvement

# Services for people with acquired brain injury

difficulties. Some staff used simple Makaton language where it was helpful to communicate with some of the patients and there were posters on ward to support this. Some patients used a digital iPad that respond to eye movements. There was also access to large print books and easy read format documents.

### Listening to and learning from concerns and complaints

The complaints policy was due for review in November 2015: this meant it was out of date. The complaints procedure provides the list of actions for both formal and informal complaints. Both must be documented using a complaints form. There were a number of ways that people could complain and there was evidence that staff had supported service users to make a complaint when service users were unable to do so.

Eight complaints were received by York House in period February 2015 to February 2016. We reviewed five complaints. The hospital had developed a local procedure for dealing with complaints based on the provider-wide complaints policy. Staff recorded complaints which were then sent to the manager, the divisional director and quality assurance.

None of the complaints were referred to the ombudsman.

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

Requires improvement

### Vision and values

York House describe their mission as providing the best quality neurobehavioural rehabilitation for persons with complex and challenging needs after neurological illness or injury.

The staff we spoke with told us the main aim of the service was to offer the best patient care. All staff appeared to be passionate about their work with patients.

Staff told us that they see the divisional manager on a regular basis and they told us the service manager operated an open door policy and was always available to speak with them.

### Good governance

The senior team had several staff members absent. The deputy service manager had been absent for over a year, one of the assistant managers had been absent for two months and the lead nurse had just left to take up another position. The provider had employed a human resources manager on a temporary contract to support the consultation and change in working patterns. Other parts of the workload had been shared with other members of the senior team. Staff across the hospital told us this had impacted on communication, they were not clear who was undertaking different aspects of the work and who they should go to for advice and support. We were told how it had also impacted on the delivery of annual performance appraisals and supervision which were behind schedule.

We saw high use of bank and agency staff on the wards at all times but especially at weekends. Staff told us they often felt vulnerable at weekends as there were only nursing staff on duty. One family also reported high use of bank and agency staff at weekends which they felt had a negative impact on communication and consistency of care. There was not always a senior member of staff available on duty at the weekends due to two senior nurses and the clinical lead leaving the service. There was always a senior staff member on call and a doctor if required. In recognition of some of the staffing difficulties, especially around weekends, the management team had recently been in consultation with the staff team to make changes to the shift system.

Compliance with mandatory training and refresher training for permanent staff was 74% for bank staff mandatory training compliance was below 75% in all areas except breakaway training which was 76%. This meant that staff members were not systematically kept updated with their training.

Staff performance appraisals were reported as 66% for care and support staff, 92% for other clinical staff and 67% for all other staff. Hospital policy stated staff should receive an annual appraisal. This meant all staff were not appraised in accordance with policy and systematically offered any training and development as might be required.

We reviewed five personnel files. We found that personnel files were kept to uniform standard and included full documentation required by the recruitment policy. All files reviewed included copies of references, disclosure and barring service (DBS) checks, eligibility to work in the UK

checks, and a pre-employment medical questionnaire and occupational health assessment. We found that recruitment procedures abided by both the recruitment policy and employer's legal obligations.

Learning from incidents was mainly through daily handover meetings. There was a shortage of available computers for staff use due to the large team on duty and staff told us it was sometimes difficult to get access to a computer to read emails. This has also highlighted a training need as during performance appraisals, some staff had highlighted that they are not confident using computers. Some staff described not receiving information about important changes and not feeling up to date.

The service has clinical leads and senior nurses on the wards. At the time of inspection there were two senior nurse vacancies. Two of the clinical leads were psychologists who were actively involved in the clinical needs of the patients rather than the administration and co-ordination of the ward. Staff described how shift co-ordination is sometimes undertaken by the senior rehabilitation support workers and sometimes by the registered nurse. It was not always clear where leadership, direction and performance management at ward level was provided.

We saw further impact on leadership and management on reviewing audit, policy and procedures. We noted five policies were passed their review date: recruitment December 2012, complaints October 2015, infection control August 2015, Mental Capacity Act guidance September 2015, Deprivation of Liberty Safeguards July 2015.

The governance lead explained how a tool had been developed to focus on collating outcomes from audits and creating actions to address issues. This was put in place to ensure that completing audits was not just seen as a paperwork exercise but that any issues found were being documented, actions identified and reviewed. We saw this audit for the last three months, however we noted that month on month some items continued to be listed with actions but there were no details regarding who was responsible or deadlines for completion.

There was a risk register but this in the early stages of implementation. Risks were general to the organisation rather than specific to the hospital and did not relate to current local issues. There was no section for monitoring or evaluating ongoing risks. The manager explained this process was under review at local level and within the disabilities trust centrally. Staff members were not aware of the risk register or how to escalate concerns onto the register.

**Leadership, morale and staff engagement**

Staff described how they could make an application for external training. Several staff members were undertaking external training for example two nurses were completing their mentorship qualification.

Morale in the team varied. The hospital was currently undergoing a change in shift patterns following a long period of consultation with the staff team. We saw presentations which had been tailor-made for different staff groups explaining why the changes were being introduced and how this would work. Several options had been debated before a conclusion was arrived at. The new working pattern was not the preferred option for all staff and some have made the decision to leave. Some others are still negotiating flexible working options to support other responsibilities outside of work. Some staff told us they were anxious about the new shift system but some staff welcomed the changes.

Team working was evident across the hospital. There was a strong team ethos and we heard and saw how staff prioritised patient care. Admin staff worked on the wards in offices. During the inspection we observed them chatting with patients. Some admin staff had previously been rehabilitation support workers and had up to date training in PMVA. This meant they were able to support nursing staff during challenging periods, especially during staff shortages on weekdays. All the staff we spoke with spoke of a team effort and we saw good working relationships between all staff groups.

There had been several opportunities for staff to input into service development through meetings and forums.

**Commitment to quality improvement and innovation**

York House did not participate in any national accreditation schemes.

Several members of the York House team received awards in 2015. The team on the Dales ward received the Disability Trust's (DT) Team award. Another staff member won the DT

Requires improvement

# Services for people with acquired brain injury

award for service and the consultant clinical psychologist was nominated for the innovations in training award by Lainge Buisson and also honoured with the Clinician of the Year award from the UK Acquired Brain Injury Forum.

# Outstanding practice and areas for improvement

## Outstanding practice

The provider hosts an annual seminar. In 2015, this was attended by 60 professionals and it included a host of information including talks and presentations describing pioneering treatment options and associated information. In previous years family members have attended and participated in presentations.

York House told us they aim to take as many service users on holiday whether it is day trips to the coast or to one of the many attractions in the area.In 2015 six service users who normally would not be able to go on holiday due to their levels of physical disability and cognitive impairments, went to a specially designed holiday cottage in the North York moors. This was funded by donations from family members and staff completing charitable events who then specified the monies to be used in such a way.Six other service users went on holiday to a number of locations: Paris, Scotland, Lake District, Centre Parks and Ireland. These trips are normally funded by the service user who is supported by either one or two staff member's dependent upon the level of support required.

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that observations are carried out and recorded following the administration of rapid tranquilisation in accordance with national guidance. This will allow for any deviance from the normal health of that patient to be recognised and actioned immediately.
- The provider must embed detailed audits of medicines management into practice and ensure that governance arrangements are put in place to analyse, learn from, and prevent re-occurrence of medicines related incidents. This will help to reduce any further errors.
- The provider must ensure that all policies are reviewed within agreed timescales and kept up to date. This will allow staff to follow up to date guidance and support a consistent approach to the delivery of patient care.
- Mandatory training, supervision and staff performance appraisal must be kept up to date, in accordance with policy. This will ensure that staff are appropriately skilled to undertake their role and any performance issues are identified and the appropriate action taken and documented.
- The provider must be able to demonstrate that the hospital has been cleaned thoroughly and checked for cleanliness. This should be clearly documented within the cleaning schedule and monitored for completion.
- The provider must ensure there is adequate space for patients to receive one to one intervention in rooms that ensure privacy and dignity is not compromised.

### Action the provider SHOULD take to improve

- The provider should ensure sufficient staffing levels at all times that involve a range of staff fully trained to deliver care and treatment to the patient group. Where bank and agency staff work across the hospital, they should be fully trained and skilled to manage the needs of the patients.
- Patients should always be offered a copy of their care plans and this should be recorded in their notes.
- The provider should have a policy in place regarding the outside doors being locked to protect the rights of patients who are not detained under the Mental Health Act from not being able to leave the building.
- The provider should ensure that room temperatures are monitored and maintained at the required temperature.
- The provider should ensure that section 17 forms are always checked for accuracy to ensure they are valid prior to patients going on leave.
- The provider should ensure that medicines requiring refrigeration are stored in accordance with national guidance by taking appropriate action immediately when temperatures fall outside the normal range. This will ensure that medicines are always stored at the correct temperature and are fit for use.

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 |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Following the administration of rapid tranquilisation , physical observations are not always carried out in accordance with national guidance**<br>**This was a breach of Regulation 12 (1), (2) (g)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**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.**<br>**The provider had not made adjustments to its policies, procedures to reflect the changes to the Mental Health Act code of practice which came into place in April 2015.**<br>**The provider had not updated five other policies which had passed their date for review.**<br>**This was a breach of Regulation 17 (1) (2) (a) (b)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>**The provider did not have cleaning schedules that were completed, monitored and audited to ensure the cleanliness of premises.** |

This section is primarily information for the provider

# Requirement notices

| | |
|---|---|
| Treatment of disease, disorder or injury | The provider did not provide adequate space for patients to receive one to one intervention in rooms that ensure privacy and dignity is not compromised.<br><br>This was a breach of Regulation 15 (1) (a) (c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Mandatory training was not completed and updated in accordance with agreed standards to ensure staff maintained the necessary skills to meet the needs of the people they care for and support.<br><br>All staff had not received regular appraisal or supervision, in accordance with York house policy, with regards to their performance in their role.<br><br>This was a breach of Regulation 18 (1) (2) (a) |