

The Retreat - York

Quality Report

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

Ratings

Overall rating for this location

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

Overall summary

We rated The Retreat York as **good** because:

- The feedback from people who used the services was generally very positive.
- The services for people with an eating disorder and personality disorder were using evidence based good practice to help people make progress with their care.
- The provider had made improvements to create a safe environment. Staffing levels enabled them to provide additional support for patients who were more vulnerable.
- There was an on-site restaurant and people were positive about the catering arrangements.
- Staff had access to training and supervision.
- The provider was working towards improving governance and staff engagement and staff felt opportunities to provide feedback had improved.

However:

- The medication management needed to improve. The measuring or monitoring of clinic room temperatures was not taking place on Naomi, Acorn and Katherine Allen wards. This meant that staff could not ensure that medicines were not exposed to temperatures higher than 25°C, as medications stored in rooms above this temperature could be less effective. Out of date medication and medicines for patients who had been discharged continued to be stored on the wards. Some patients were prescribed medication to be given as required, without a clear record of the reasons for this medication.
- Older patients who were at risk of a fall did not have plans in place to ensure this was mitigated by wearing safe footwear. Activities for people with dementia needed to improve to meet their specific needs.
- Although there were systems in place for whistleblowing staff did not feel comfortable using them to be assured that their concerns would be addressed.

Summary of findings

Our judgements about each of the main services

Service

Wards for older people with mental health problems

Rating Summary of each main service

We rated The Retreat as good because:

- wards were clean, tidy and well maintained
- although the ward layouts did not allow staff to observe all parts of the wards the provider had mitigated this risk by the use of staff and placing of observation mirrors
- staff understood local safeguarding procedures, their responsibilities and how to raise concerns
- staff recorded comprehensive assessments and plans of care, including assessments of, for example, nutrition, physical health, violence/aggression risks, mental health and mobility (falls)
- the provider had a comprehensive mandatory training programme
- patients and relatives gave excellent feedback about the staff providing the care and the progress their relatives had made
- we observed excellent interactions between staff and patients across all services and staff worked in collaboration with patients as partners in their care
- the Katherine Allen unit received accreditation by the Accreditation for Inpatient Mental Health Services on 15 January 2014 and met all of the standards required.

Good



However:

- the hospital had no robust medicines management process and there were problems in the service level agreement for the safe and effective disposal of medication
- the environment on the George Jepson unit did not reflected best practice in dementia care and was not designed to meet the needs of the patient group
- staff's mobility/falls assessments of patients on the George Jepson unit did not cover footwear and the associated risks to the patients' mobility despite a falls serious incident
- there was little evidence of any range of patient activities on the George Jepson unit

Summary of findings

- there was inconsistent discharge planning on the wards for older people with mental health problems
- the senior management team had not consulted adequately with staff and patients on recent ward closures and changes to the ward environment
- there were inconsistencies in the multidisciplinary team (MDT) meetings that took place on the older people's wards, with a lack of evidence of comprehensive multidisciplinary team reviews of patients' care
- there was a lack of junior medical cover to support the consultant psychiatrist
- effective governance systems, which allow mechanisms for accountability and oversight of the entire hospital, were still being implemented and not fully incorporated into the services.

Specialist eating disorders services

Good



We rated The Retreat - York (Naomi Ward) as good because:

- the service used well-established evidence-based guidance for care and treatment of patients, with clear pathways
- staff were respectful and empathetic, and provided emotional support
- patients told us staff were caring
- staff understood the local procedures for safeguarding patients from abuse, what their responsibilities were and how to raise their concerns
- staff completed comprehensive assessments of patients' needs and their care plans demonstrated meeting patients' physical and mental health needs
- staff kept care records up to date and stored them safely.

However:

- the hospital had no robust medicines management process and there were problems in the service level agreement for the safe and effective disposal of medication and care plans did not always contain sufficient detail for patient as prescribed PRN medication, medication taken when it is required

Summary of findings

- staff were not following the care programme approach (CPA) or sharing information for discharge planning in a timely way, which meant services were not working together to deliver effective care and treatment
 - senior management had not consulted adequately with staff regarding alterations to the ward that affected patient care, which meant staff and patients had not been fully involved and engaged in the planning and delivery of services on the ward.
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Summary of findings

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Good



The Retreat York

Services we looked at

Wards for older people with mental health problems, specialist eating disorders services and personality disorder services.

Summary of this inspection

Background to The Retreat - York

The Retreat York is an independent provider of specialist mental health services, which works closely with the NHS to provide services for people with complex and challenging behaviours. The hospital has six wards. Four of these were open at the time of our inspection. These included wards for older people with mental health problems, specialist eating disorders services and personality disorder services. Current regulated activities include assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures, personal care and treatment of disease, disorder or injury. The services had a registered manager and accountable officer.

The George Jepson unit is a service with 13 beds for male patients. It provides care and treatment for older people with mental health problems such as dementia and other disorders. It supports patients who may have challenging behaviour.

The Katherine Allen unit is a service with 12 beds for female patients. It provides care and treatment for older people with mental health problems who have a primary diagnosis of a functional disorder such as depression or psychosis or an organic disorder such as dementia. It supports patients who may have challenging behaviour.

Naomi ward is a service with 14 beds for women with a diagnosed eating disorder. It specialises in treating people with more than one diagnosis, which may include personality disorder, obsessive-compulsive disorder and complex post-traumatic stress disorder. Naomi ward is a modified therapeutic community that uses a programme of group and individual therapy to help people take responsibility for their own recovery. In addition, Naomi ward has access to Spring Lodge, a two-bedroomed building in the grounds of The Retreat. Naomi ward and the Acorn unit share Spring Lodge to help patients in their recovery. Spring lodge was not registered as a separate location of the Retreat.

The Acorn unit is a therapeutic community service with 14 beds for women with borderline personality disorder or complex post-traumatic stress disorder. The unit provides a range of therapeutic approaches. The Association of Therapeutic Communities has accredited the unit.

The Retreat also provides a counselling, therapy and psychological assessment service from the Tuke Centre. We did not make a comprehensive inspection of this service but we visited the centre, spoke with staff and reviewed patient comments as part of the main inspection.

The Retreat has been inspected on five occasions. There was a recent focussed inspection of the George Jepson unit on 10 May 2015. The inspection followed an anonymous whistle-blowing concern and safeguarding investigation. The inspection identified staffing shortages and the service provider has a clear plan to deal with this issue. The focused inspection findings are incorporated into this comprehensive inspection report.

An inspection conducted on 22 October 2013 found The Retreat compliant with regulations on consent to treatment, care and welfare of people who use services, management of medicines, supporting workers, and complaints.

There have also been two Mental Health Act (MHA) review visits. The first visit took place on the Allis unit on 23 January 2015 and the second on the Katherine Allen unit on 30 January 2015. The MHA review visits found the services did not consider plans for patient discharge during patients stay. There was a lack of evidence of comprehensive MDT reviews of patients' care. Other previous inspections were found to be compliant with consent to treatment; care and welfare of people who use services; management of medicines; supporting workers and complaints.

Our inspection team

Team leader: Senga McMorrow, Inspector (Mental Health) CQC

Jo Walkinshaw, Inspection Manager (Mental Health) CQC.

Summary of this inspection

The team that inspected the service consisted of sixteen people: four CQC inspectors and a variety of specialists. The latter were a nurse consultant for eating disorders, nurse specialist for older people with mental health problems, consultant psychiatrist, occupational therapist, consultant psychologist in personality

disorders, social worker, pharmacist, two specialist governance advisors, a specialist advisor in civil engineering, a Mental Health Act reviewer and an expert by experience. All these specialists had recent mental health services experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients.

We carried out an announced visit on 27 and 28 October 2015.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service and collected feedback from 30 patients using comment cards

- spoke with the registered manager and managers for each of the four wards
- spoke individually with 21 other staff members; including doctors, nurses, occupational therapists, psychologists, a physiotherapist, a visiting pharmacist, social workers, support workers
- held six staff focus groups and 15 individual interviews with directors, trustees and the senior management team staff
- received feedback about the service from commissioners
- spoke with two independent advocates
- attended and observed two hand-over meetings, three multi-disciplinary group/patient meetings
- conducted a short observational framework for inspection (SOFI) exercise
- looked at 14 care and treatment records of patients
- carried out a specific check of the medication management on all four wards, which included reviewing all medication drug prescription charts; and looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the service say

Patients who we were able to speak with said they had good relationships with staff and staff treated patients with dignity and respect. They told us they felt safe.

Patients told us they were unhappy with the senior leadership team because they had not listened to

Summary of this inspection

patients or involved them in recent changes. We were unable to speak with all patients because some were living with severe dementia. Relatives gave very positive feedback about all aspects of care.

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:

- Improvements needed to take place in medicines management. Staff did not measure or monitor clinic room temperatures on Naomi, Acorn and Katherine Allen wards. This meant that staff could not ensure that medicines were not exposed to temperatures higher than 25°C, which could potentially damage the medication.
- Out of date medication and medicines for patients who had been discharged continued to be stored on the wards. At the time of our inspection, there was no agreement with a pharmacist to ensure that medication was disposed of safely.
- Patients prescribed medication to be taken as required did not always have a record of why this medication was being used.
- The provider had not ensured that on the wards for older people that patients at risk of a fall had risk assessments and plans in place to ensure they wore safe footwear. We observed some patients wearing unsafe footwear.

However:

- The provider had identified ligature point risks across all four wards. Regular environmental risk assessments were undertaken and staff were fully aware of these. Steps had been taken to mitigate these risks.
- There was a comprehensive mandatory training programme in place.
- The hospital had training and policies in place to ensure restraint where needed was used safely.
- The provider had identified staffing problems and had undertaken a review of staffing across its services. The ward managers had oversight of the wards and the authority to adjust the staffing levels if required.

Are services effective?

Good



We rated effective as **good** because:

- Each patient had a comprehensive assessment and care plan. Patients received regular physical health checks.
- Staff planned the care and treatment with patients during the initial assessment including discharge arrangements.
- Three of the four wards had achieved various accreditation standards reflecting standards of best practice.

Summary of this inspection

- The teams across the services consisted of a range of mental health professionals.
- Staff had received training in the Mental Health Act and the Mental Capacity Act and had a good understanding of the principles.

However:

- On the George Jepson ward, we found that some patients did not have a record of their care co-ordinator to help plan their discharge. This was not solely about the recording of contact with their care co-ordinator but because of the distance some patients were from their local services and agencies.

Are services caring?

We rated caring as **good** because:

- We observed excellent interactions between staff and patients. Staff worked with patients in collaboration as partners in their care.
- Patients told us they had good relationships with staff and were treated with dignity and respect.
- The services demonstrated a patient-centred approach to individual patient choice and wishes.
- Patients were offered a copy of their care plans.
- Care plans showed that staff included patients and relatives in their care and treatment.
- The patient lead was an expert by experience employed by the provider who was able to represent the views of the patients to all levels of the provider organisation.

Good



Are services responsive?

We rated responsive as **good** because:

- When patients went on leave they always had access to a bed on their return.
- The service employed catering staff and had a canteen and restaurant on site, used by patients and staff. The food quality and choice were good and patients had the option to make drinks at all times.
- Patients could request meals that reflected their religious or cultural background or personal choice.
- Patients were given information about the care and treatment they could expect to receive whilst on the wards that included how to make a complaint.

However:

Good



Summary of this inspection

- On the wards for older people the therapeutic activities did not meet the needs of patients with dementia.

Are services well-led?

We rated well-led as **good** because:

- Staff understood the vision and values of the provider.
- Initiatives had been implemented to improve communication with staff, including engagement opportunities where staff could feedback on services
- Staff told us they could discuss concerns with their immediate line managers.
- Staff knew who the senior managers were within the organisation and they were visible on the wards. Initiatives had been implemented to improve communication with staff, including engagement opportunities where staff could feedback on services.

However:

- Although there were systems and processes in place to allow staff to report issues of concern, these had not been utilised by staff as several had raised whistleblowing concerns with the CQC.

Good



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.

The provider had employed a Mental Health Act (MHA) administrator who oversaw all matters relating to the MHA. The services were adhering to the MHA and MHA Code of Practice. The MHA administrator also provided training and advice for ward staff. Staff had a good understanding of the MHA Code of Practice and 89% of staff had received training in the MHA.

Patients detained under the MHA were made aware of their rights on a regular basis. Patients were supported to access independent mental health advocates, appeal to a tribunal and take section 17 leave.

There had been two MHA review visits within the last 12 months. The service was found to be compliant with the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider was adhering to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The provider had made 21 Deprivation of Liberty Safeguard (DoLS) applications between the 17 January 2014 and 08 September 2015.

There was good compliance with the provider's mandatory Mental Capacity Act training and 80% of staff had completed this training.






Staff also demonstrated a good understanding of the Mental Capacity Act and its principles.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Specialist eating disorder services	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement 

Safe and clean environment

- Within the older peoples wards there were ligature points in the bedrooms. Further ligature risks were noted within communal areas and bathrooms of the wards. Staff monitored these risks within the local ward risk registers. Regular environmental risk assessments were undertaken. The provider had further mitigated the risks through placing an additional member of staff within a corridor area (on George Jepson), individual patient observation levels and the installation of observational mirrors.
- The ward areas were clean and well maintained with a programme for furniture replacement and upgrade and patients had the option to personalise their bedrooms
- The wards complied with guidance on same-sex accommodation as each ward was a single gender ward.
- Whilst patients were assessed for the risk of falls, the assessments on George Jepson ward did not cover footwear and the risks that this may have had on the patients' mobility. Patients were observed to be wandering in corridors on floor surfaces that could compromise their safety without wearing appropriate footwear to keep them safe. This was despite a recent serious incident where a patient fell and was not wearing appropriate footwear.

- The clinic rooms were fully equipped with access to equipment for physical examinations and resuscitation. Resuscitation equipment was regularly checked.

Safe staffing

The key staffing for The Retreat York as reported by the hospital covers the period between September 2014 and the end of August 2015.

- The established staffing complement for the service was 118 whole time equivalent (WTE) staff. This included 50 WTE qualified nurses, and 69 WTE support workers. Between 1 May and the end of July 2015, the service reported 6 vacancies for qualified staff and 4 vacancies for nursing assistants. During this period, the sickness absence rate was 3%. Staff turnover was 15%.
- The provider had undertaken a review of staffing across its services as it had recognised that staffing shortages were a problem across its services particularly within the older peoples wards. However this had not been ratified by the board or published at the time of inspection. The older people's wards had also introduced a range of shift patterns across the wards. There was variation in their daily staffing establishment to reflect the needs of the patients. On the George Jepson unit the normal establishment was six staff during days and five at night. Two of the staff on each shift were registered nurses. The provider had bank or agency staff to cover vacancies, sickness, absence and one to one patient observation. During the three month period leading to the inspection 272 shifts of bank or agency staff had been used on the older people's wards. There were three patients who required one to one nursing support. The manager was able to adjust the staffing levels as required.
- The wards had a qualified nurse on duty at all times.

Wards for older people with mental health problems

- There was a comprehensive mandatory training programme and the overall provider training rate compliance was 83%. The provider training programme demonstrated a level of achievement across its training programme such as adult safeguarding 100%, Mental Capacity Act 80%, MHA 89% and risk awareness 97%.

Assessing and managing risk to patients and staff

- There were no seclusion facilities.
- The hospital practiced restraint and had a restraint policy. The older people's wards accounted for 49 incidents involving 12 patients over the 6 month period prior to the inspection. No prone restraint was used. The recording of incidents of restraint was not comprehensive.
- We reviewed eight care records across both of the older people's wards. There were processes in place for the observation of patients. Routine observations took place every 15 minutes. At the time of our inspection, there were three patients on one to one observations within the male ward.
- There were concerns that the clinic room temperatures were not being measured or monitored as required. This meant that there was no guarantee that medication was stored at the correct temperature and medication could potentially be damaged from storage at high temperatures.
- Staff had received training in safeguarding adults and children and understood the local safeguarding procedures. There was a safeguarding lead identified in the team and they worked in collaboration with the safeguarding lead within the hospital. Safeguarding was clearly embedded across the service. There were good links with the local authority, confirmed by the local authority, staff and care records.

Track record on safety

- There was one reported serious incident on the male older peoples unit of a fall resulting in a broken hip. There were no reported serious incidents for the female older peoples ward.

Reporting incidents and learning from when things go wrong

- We saw some evidence of learning lessons when things had gone wrong, for example from medication errors. This had also been recorded on the risk register. In response, the provider had introduced competency

based staff training, and the escalation of all medication error incidents through the incident reporting system and to the team manager. There were further areas of development required in relation to all lessons learned such as the falls incident and the relationship to patient footwear assessments.

Are wards for older people with mental health problems effective? (for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We reviewed nine care records. There were comprehensive assessments and plans of care held within the care records which incorporated assessments for example on nutrition, physical health, violence and aggression risks, mental health. Records demonstrated that patients received regular physical health checks including electrocardiography (ECG).
- The services demonstrated a patient-centred approach to individual patient choice and wishes. However, it was unclear how this was care planned particularly when patients were spending long periods in their bed space on George Jepson.
- All patient medication charts, clinic rooms and medication trolleys were reviewed during the inspection. However we found there was a lack of a robust medicines management process, with the wards holding a large stock medication. There were also problems identified in the service level agreement for the safe and effective disposal of medication that was out of date or belonged to patients who were no longer using the services. The provider had identified issues within its medicines management and there was evidence of lessons learned around medication errors and the recording of errors. However, there were also further problems recognised with the management and recording of PRN medication, medication that taken when required in patient care plans.

Best practice in treatment and care

- The Katherine Allen Unit received accreditation by the Accreditation for Inpatient Mental Health Services on 15

Wards for older people with mental health problems

January 2014 and met all of the standards required. The Katherine Allen unit had also been involved in a number of initiatives to enhance the environments for the patient group beginning in January 2015 with staff wearing particular uniform colour and patients having food served on a range of coloured plates. The George Jepson unit ward was in a period of transition. The provider had identified 11 out of 13 of those current male patients had dementia, who were in an environment not designed to meet their needs. A process had begun to look at ways of moving forward towards a dementia friendly environment to meet the needs of this patient group. Therefore the service did not demonstrate best practice and standards for people with dementia.

- There was little evidence of any range of activities on the George Jepson unit during the inspection visit. We were told the activities co-ordinator was off sick. However, staff reported that even when the activities co-ordinator was available, one person was not sufficient to provide the range of activities required to meet the needs of the patient group.
- The location employed a physiotherapist who had implemented a falls programme. However, staff on the ward were unable to tell us about the programme and the three patients who had been assessed.

Skilled staff to deliver care

- There was a range of mental health professionals both ward based and within the main hospital site, including a psychiatrist, psychologists, social workers, a physiotherapist and occupational therapists
- Staff on the wards for older people with mental health problems were predominantly Registered Mental Nurses(RMN)
- The service medical cover comprised of consultant psychiatrist however there was a lack of junior medical cover to support the psychiatrist
- staff had received regular supervision and had annual appraisal of their work performance.

Multi-disciplinary and inter-agency team work

- There was a variation in the multidisciplinary team (MDT) meetings which took place and what these were known as, including multi-disciplinary team meetings and care programme approach meetings. There were weekly formulation or management meetings which reviewed individual patient cases in more depth on the

George Jepson Unit. However there was a lack of evidence of comprehensive multi-disciplinary team reviews of patients' care and how these decisions were implemented on the wards.

Adherence to the MHA and the MHA Code of Practice

- There was a Mental Health Act monitoring visit carried out on the male ward during the inspection visit, which reviewed five care records and discussions with two patients. The previous Mental Health Act monitoring visit occurred on 24 September 2013, which identified issues regarding the recording of capacity to consent, not found on this visit. Eighty-nine per cent of staff had received training in the Mental Health Act and had a good understanding of the Code of Practice and its guiding principles.
- There were 17 patients detained under the Mental Health Act at the whole location, 2 informal patients and seven patients subject to Deprivation of Liberty Safeguards
- Section 17 leave, medication certificates for consent to (T2) and treatment (T3) were all in place. The provider employed a fulltime mental health act administrator who oversaw all matters relating to the Mental Health Act, paperwork, legalities, monitoring and audit. They also provided training and advice for ward staff.
- Patients had access to independent mental health advocates, who had an office at the location.
- Patients' care records demonstrated that staff had tried to inform patients of their rights under section 132 of the Mental Health Act 1983 and despite comprehension difficulty of patients, this process was repeated and the patient's responses recorded.

Good practice in applying the MCA

- Eighty per cent of staff had received training in the Mental Capacity Act. Staff accessed the mandatory Mental Capacity Act training and had a good understanding of its principles.
- The provider had made 21 Deprivation of Liberty Safeguarding (DoLS) applications between 17 January 2014 and 08 September 2015

Are wards for older people with mental health problems caring?

Wards for older people with mental health problems

Good 

Kindness, dignity, respect and support

- We observed excellent interactions between staff and patients. Staff worked in collaboration with patients as partners in their care. Staff demonstrated respect and understanding of patient needs and level of emotional support that was required.
- We were unable to speak with all of the patients because of the severity of their dementia but their relatives gave good feedback about all aspects of care. Patients who could speak with us told us they had good relationships with staff and were treated with dignity and respect.
- The services demonstrated a patient-centred approach to individual patient choice and wishes.

The involvement of people in the care they receive

- Care plans showed that staff included patients and relatives in their care and treatment, especially where patients had difficulties with comprehension
- There was evidence that relatives and carers were involved around all aspects of the Mental Capacity Act and Mental Health Act
- The patient lead was an expert by experience employed by the provider who was able to represent the views of the patients to all levels of the provider organisation.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good 

Access and discharge

- The older people wards occupancy was 98% and 95%, there appeared to be little impact of occupancy rates on admission or discharge due to funding arrangements for admission. The provider had undertaken a review of the all of the wards.

- Patients came into the service from a variety of catchment areas as agreed with the funding authorities, this could involve longer distances to the patients home
- There were no issues identified with access to beds if patients went on periods of leave
- Patient discharges occur in collaboration with the provider, funding authority and the patient. Although discharge planning was evident on Katherine Allen, this was not evident on The George Jepson unit.

The facilities promote recovery, comfort, dignity and confidentiality

- The services are located within an older listed building set in green space on the outskirts of York, which caused some difficulties in what can be achieved within the building fabric and restrictions. Despite this the provider has attempted to ensure that there are a range of facilities and equipment to meet the care needs of the patient population. There are: quiet areas; rooms for visitors; patients can personalise bedrooms; access to phones. Although there is access to outside space for those wards on the upper floor of the main hospital building this was a stark and drab outside environment that offered little therapeutic value. The provider had a plan of works in place to improve this facility for patients.
- There had been a recent undertaking of painting of the corridors and bathroom doors in dementia friendly colouring. Bathroom door colours were found not to be painted on both sides of the doors and would not support dementia patients to exit bathrooms easily. Gradually older furniture was being replaced with more dementia friendly furniture. Patients had the option to personalise their bedrooms and were able to go into their bedrooms in privacy. However bedroom doors lacked viewing observation panels and opened out into the main corridor. This could increase the potential risk to patients if they were in the immediate vicinity when anyone was exiting a bedroom and also meant that staff undertaking observational checks during the day and night were required to enter the patients bedrooms potentially impacting on their privacy and dignity. The environment did not reflected any other best practice in dementia care.
- All patients were registered with a local GP practice and there were weekly G.P. visits into the whole location to look at physical health assessments and treatment of the patients.

Wards for older people with mental health problems

- The access to activities varied across the services and weekends. This was particularly evident on the George Jepson unit where there were no meaningful activities throughout the duration of the inspection, despite there being an activities coordinator in post. During the inspection they were off sick. In their absence, there was no evidence of any meaningful dementia friendly patient activities done and staff commented that the role was unachievable for one person even when the activities co-ordinator was available.
- The service employed catering staff and has a canteen and restaurant on site, used by patients and staff. The food is good quality and choice. The food hygiene rating awarded by the local authority, city of York council, in June 2015 was three, generally satisfactory. There was the option to make hot drinks and snacks and for staff to support patients who were less able.

Meeting the needs of all people who use the service

- The catering facilities and staff can meet the dietary requirement needs of any religious or ethnic background
- There was access to a range of spiritual and faith support facilitated by the Quaker chaplain. Demonstrated recently following the death of a Catholic patient, the hospital met the family and patient wishes.

Listening to and learning from concerns and complaints

Staff knew how to handle complaints appropriately and managed complaints at ward level. Relatives told us they knew how to complain and said they would be confident in doing so.

Are wards for older people with mental health problems well-led?

Good 

Vision and values

- Staff understood the vision and values of the provider. However the senior management team had not consulted adequately with staff regarding recent ward closures and changes to the ward environment. This resulted in staff and patients raising concerns around the mismatch between the provider values, the

therapeutic community approaches and the management of risk by the services. Information shared with inspectors by patients and staff during the inspection corroborated with information on CQC comment cards.

- staff knew who the senior managers were within the organisation and they were visible on the wards.

Good governance

- The provider had implemented changes to improve the governance structure to ensure effective systems and processes for the future. Work around this was still on going.
- The provider had systems and processes in place to ensure that staff received mandatory training, supervision and appraisal
- The provider undertook a comprehensive analysis of staffing following persistent difficulties with recruitment, retention and sickness. Despite review by the board for consideration and approval, no decision or plan regarding the preferred options for the provider was agreed.
- There was evidence of learning from incidents and how this could be used to improve patient care.

Leadership, morale and staff engagement

- Initiatives implemented to improve communication with staff, had enhanced staff engagement and opportunities where staff could feedback on services. Many staff spoke positively about these across the services.
- There were three recent whistleblowing concerns raised to CQC about the provider. Although there are systems and processes in place to allow staff to report issues of concern, these concerns were raised anonymously.
- Staff reported the new reporting methods introduced to manage medication errors was perceived by some staff as a punitive approach by senior management to managing medication errors rather than encouraging reporting.






Commitment to quality improvement and innovation

The hospital wanted to provide the best possible care and treatment practices across services. There were recognised quality and innovation achievements within its accredited

Wards for older people with mental health problems

services, for example involvement in research by the Acorn unit. However there were still many improvements which were required particularly within its older people services before innovation and quality could be achieved.

Specialist eating disorder services

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

Information about the service

Naomi ward is a service with 14 beds for women with a diagnosed eating disorder. It specialises in treating people with more than one diagnosis, which may include personality disorder, obsessive-compulsive disorder and complex post-traumatic stress disorder. Naomi ward is a modified therapeutic community that uses a programme of group and individual therapy to help people take responsibility for their own recovery. In addition, Naomi ward has access to Spring Lodge, a two-bedroomed building in the grounds of The Retreat. Naomi ward and Acorn unit share Spring Lodge to help patients in their recovery.

Summary of findings

The Naomi unit was a well established eating disorder service that had a clear care and treatment pathway and good links with local services.

Specialist eating disorder services

Are specialist eating disorder services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- the service had no robust medicines management process to keep people safe and care plans did not always contain sufficient detail for patient PRN medication (medication taken when it is required)
- There was evidence of a blanket restriction affecting all informal patients using the communal courtyard. The senior management team took the decision to close the courtyard despite the risk register detailing the risks and a plan of work in place to address the risks.
- Spring Lodge had no anti-ligature furniture and fittings therefore patients were not always ensured safe care and treatment provision.

However

- staff did thorough assessments of the risks to patients when they were admitted
- staff understood the local safeguarding procedures, what their responsibilities were and how to raise their concerns
- patients said they felt safe on the ward
- staffing levels were adequate to meet the needs of the patients and adjusted appropriately when necessary
- the ward was visibly clean and tidy and equipment was well maintained
- staff knew how to report incidents. Incident reporting and shared learning from incidents was apparent on the ward.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good 

We rated effective as **good** because:

- There was well-established evidence based guidance for care and treatment on the ward, with clear pathways

- staff completed comprehensive assessments with patients and
- patient care plans described how their needs were met
- staff kept care records up to date and stored them safely
- staff received training to improve their skills and knowledge to support patients
- the Consultant Psychiatrist was highly visible and accessible on the ward
- staff received regular managerial supervision and had annual appraisals of their work performance
- all staff had received training in safeguarding adults
- there was a system in place to check the competence of staff to administer medicines
- patients were required to complete a pack of outcome measures which were self-report questionnaires. Patients completed these at assessment, on admission, before CPA reviews, on discharge, at 3 month intervals for 12 months post discharge.
- Staff demonstrated a good understanding of the Mental Capacity Act and its principles. We saw evidence patients agreed and signed their care plans. This meant that staff always sought consent for care and treatment. The hospital reported good compliance with mandatory Mental Capacity Act training, where 80% of staff had received this training.

However

- staff did not always follow the care programme approach (CPA) and discharge planning lacked the timely sharing of information. This meant services were not working together to deliver effective care and treatment.
- there was no access to junior medical staff to support the consultant psychiatrist.

Are specialist eating disorder services caring?

Good 

We rated caring as **good** because:

- Staff were respectful, empathetic and provided emotional support and patients told us staff were caring
- daily patient meetings took place and we saw evidence of how the patients' voice influenced what happened on the ward

Specialist eating disorder services

- patients were complimentary about the service and staff who supported them
- staff treated patients as partners in their care
- staff involved patients in the delivery of services on the ward.

Are specialist eating disorder services responsive to people's needs? (for example, to feedback?)

Good 

We rated responsive as **good** because:

- the multi-disciplinary team discussed all referrals to the ward on a weekly basis. Admission and discharge arrangements were planned according to individual patient needs.
- the ward environment had a range of therapy rooms and space which addressed patient recovery, comfort, dignity and confidentiality
- patients told us they could raise their concerns and knew how to make a complaint

However

- in exceptional circumstances, staff told us patients were admitted to the ward without a care co-ordinator which caused difficulties in establishing community links and delayed the patients discharge

- patients' privacy was not always protected from others. For example, there were seats situated outside directly under the lounge windows that were accessible to anyone using the hospital grounds.

Are specialist eating disorder services well-led?

Good 

We rated well-led as **good** because:

- There was clear learning from incidents
- the ward had been proactive in capturing and responding to patients concerns and complaints
- staff felt they could discuss their concerns with their line manager or more senior managers without fear of victimisation
- the ward team were committed to quality improvements and felt involved in the development of the ward.
- The ward had a clear model of care and vision statement with patients offered treatment using the Pathways to Recovery model.

However

- senior management had not consulted adequately with staff regarding alterations to the ward environment that influenced patient care. Therefore, staff and patients had not been fully engaged and involved in the planning and delivery of services on the ward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

The provider must ensure that:

- The provider must ensure that clinic rooms are the correct temperature, that there are arrangements in place to dispose of out of date medication and that where patients are prescribed as required medication that the reasons for this are clearly documented.
- The provider must ensure that where patients are at risk of a fall that the plan to mitigate this risk includes ensuring the patient has safe footwear.

Action the provider **SHOULD** take to improve

- The provider should ensure that activities are provided on the wards for older people that meet the needs of people with dementia.
- The provider should ensure that staff are well informed about internal whistle-blowing processes.
- The provider should ensure that on the wards for older people they always have a record of the care co-ordinator to assist with discharge planning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for patients. The risks must be assessed and all that is reasonably practical should be done to mitigate the risks.</p> <p>We found that the provider had not ensured the proper and safe management of medicines by ensuring they were stored at a safe temperature, disposing of unwanted medicines safely and ensuring that patients who were prescribed as an when medicines have a clear record of the reasons for this.</p> <p>We found that patients at risk of falls had not got comprehensive plans in place to mitigate this risk including wearing safe footwear.</p> <p>This was a breach of regulation 12 (1)(2)</p>