Schoen Clinic 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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Requires improvement
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.

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 **Kemp Unit** at Schoen Clinic - York as **requires improvement** because:

- The unit did not have enough nurses to meet the needs of the patients. Staffing numbers met the establishment levels however patients told us escorted leave and activities were cancelled or rearranged and post therapy support was not always offered. The unit did not monitor this.
- The service did not meet its safeguarding responsibilities. Staff training on how to recognise abuse was not role dependant and did not meet the requirements specified in intercollegiate guidance. A clear framework which identifies the competencies required for all healthcare staff.
- Feedback from some patients and family members indicated that not all staff treated patients with dignity and respect.
- The unit did not provide the least restrictive environment possible in order to facilitate patients' recovery. The unit applied blanket restrictions which were not indicated on their blanket restrictions register. Patients could not access the laundry room, sensory room or snug without staff supervision. Patients could only eat their meals in the dining room.
- Governance processes did not always operate effectively. We identified issues with staffing levels, safeguarding, appraisals, blanket restrictions, fire safety and occupational health and safety monitoring.
- Not all staff felt respected, supported and valued, which was reflected in staff survey results reported in September 2019.

However:

- The unit environments were clean. Staff assessed and managed risk well. They minimised the use of restrictive interventions and managed medicines safely.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The unit teams included or had access to the full range of specialists required to meet the needs of patients on the unit. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. The unit staff worked well together as a multidisciplinary team and with those outside the unit, who had a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff actively involved patients, families and carers in care decisions.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

We rated **Naomi Unit** at Schoen Clinic – York as **requires improvement** because:

- The unit did not have enough nurses. Staffing numbers were not enough when the unit was at full capacity and accepting new admissions. The provider didn't always meet the minimum staffing levels or have enough staff to cover all patient observations or facilitate group sessions. Trips were cancelled or rearranged.
- The service did not meet its safeguarding responsibilities. Staff training on how to recognise abuse was not role dependant and did not meet the requirements specified in best practice guidance written in conjunction with professional bodies.
- The layout of the unit did not fully ensure patients' privacy and dignity. Staff measured patients' blood pressure on the corridor in front of other patients, visitors and staff. Patients were weighed in the small clinic room because it was more accessible than the treatment room. On the main corridor patients signed up to book appointments with staff on the 'opt in' board. This meant that other patients and visitors were able to see what patients were attending.
- Governance processes did not always operate effectively. We identified issues with staffing levels, safeguarding, appraisals and development, blanket restrictions, frequency of team meetings, privacy and dignity, fire safety and occupational health and safety.

Summary of findings

- The provider had no leadership development or additional training for qualified nurses. Managers did not support all staff with appraisals and supervision.
- Staff did not all feel respected, supported and valued.
- Staff struggled to describe innovations that were taking place in the service or quality improvement methods that they participated in.

However:

- The unit environments were clean. Staff assessed and managed risk. They minimised the use of restrictive practices and managed medicines safely.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The unit teams included or had access to the full range of specialists required to meet the needs of patients on the unit. The unit staff worked well together as a multidisciplinary team and with those outside the unit, who had a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working-age adults	Requires improvement 	
Specialist eating disorders services	Requires improvement 	

Summary of findings

Contents

Requires improvement

Schoen Clinic York

Services we looked at

Long stay or rehabilitation mental health wards for working-age adults; Specialist eating disorders services;

Summary of this inspection

Background to Schoen Clinic York

Newbridge Care Systems Limited is the registered provider for Schoen Clinic - York. Schoen Clinic York has been registered with CQC since 9 January 2019. This was their first inspection. The units had previously been managed by another provider.

The CQC registered Schoen Clinic - York to carry out the following legally regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostics and screening procedures
- Treatment of disease, disorder or injury

During the inspection we visited:

- **The Kemp Unit,** an eight-bed unit for women with complex personality and dissociative identity disorder. Whilst the focus is on trauma, treatment may also include the management of co-morbidities such as addictions and eating disorders. Kemp operates as a modified therapeutic community, using a programme of group and individual therapy to support patients in their recovery.
- **The Naomi Unit**, a 15 bed specialist eating disorder unit for women with complex needs. The team specialises in treating women with more than one diagnosis, which may include personality disorder, obsessive compulsive disorder and complex post-traumatic stress disorder. Naomi operates as a modified therapeutic community, using a programme of group and individual therapy to support patients in their recovery.

During the inspection there was no registered manager in place. However, the hospital manager had submitted their application to the CQC which was being processed. Following the inspection the manager's application was approved.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one assistant inspector, one nurse specialist adviser and one occupational therapist specialist adviser.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme following a change in registration.

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 and asked other organisations for information.

During the inspection visit, the inspection team on **Kemp Unit**:

Summary of this inspection

- visited the Kemp unit, looked at the quality of the unit environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with two family members of patients using the service
- spoke with the deputy unit manager
- spoke with the responsible clinician
- spoke with 13 other staff members; including nurses, nurse associate, occupational therapist, social worker, dietician, psychology assistant, healthcare assistants, Mental Health Act administrator, clinical manager and housekeeper
- attended and observed a care programme approach meeting, a multidisciplinary handover meeting the provider called a report out, a community meeting and a music group
- looked at six care and treatment records of patients
- carried out a specific check of the clinic room and medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

During the inspection visit, the inspection team on **Naomi Unit**:

- visited the Naomi unit, looked at the quality of the unit environment and observed how staff were caring for patients;
- spoke with six patients who were using the service;
- spoke with three carers or families whose relative was using the service;
- spoke with the deputy unit manager;
- spoke with 17 other staff members; including the clinical manager, operations manager, doctors, nurses, support workers, nutrition support worker, occupational therapist, dietician, social worker, assistant psychologist, housekeeper, human resources adviser and Mental Health Act lead;
- attended and observed one hand-over meeting, one multi-disciplinary meeting, one referrals meeting, one medicines round and one supported drinks group;
- collected feedback from two patients using comment cards;
- looked at six care and treatment records of patients;
- carried out a specific check of the medicines management on the unit
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

On **Kemp unit** we spoke with four patients and two family members. There was a mixed response from patients and families. Two patients and a family member told us not all staff in the service treated patients with dignity and respect.

Two patients and one family member shared concerns about the staffing levels. They described how escorted leave and activities had to be cancelled, post therapy support was not always being offered and one patient did not always feel able to approach staff for support.

Patients and family members told us they knew how to complain and raise concerns. Both family members had raised concerns and the unit had responded to their concerns.

However, patients described how staff worked collaboratively with them and how their physical health and mental health needs were met. Patients and one family member were positive regarding the therapeutic groups and activities in the service, links to external services and the community.

On **Naomi unit** we spoke with six patients, three carers or family members and received two comments cards from patients. All spoke positively about the pathways to recovery program and the therapeutic community. Patients felt empowered and said the program equipped them with the skills they needed to recover. Families and carers told us they were kept informed and were fully involved in their loved one's care.

Patients, families and carers spoke positively about staff in the service. They described how staff worked collaboratively with them and how their physical health and mental health needs were met.

Summary of this inspection

However, all patients shared concerns about the number of patients on the unit and staffing levels. They described how trips out and activities had to be cancelled, and some said that they did not always feel able to approach staff for help.

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.

On **Kemp uni**t we found staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

94% of nursing staff had had training in the Mental Health Act but support workers did not complete this training as mandatory.

Staff had easy access to administrative support on site for advice on implementation of the Mental Health Act and its Code of Practice and the provider had relevant policies and procedures that reflected the most recent guidance.

Patients had easy access to information about independent mental health advocacy.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. There was a separate file for section 17 leave for detained patients and available to all staff that needed access to them.

Staff requested an opinion from a second opinion appointed doctor when necessary. The detained patients Mental Health Act paperwork and prescriptions corresponded.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

On **Naomi unit** at the time of inspection there were no detained patients on the unit. However, staff explained patients their informal rights. Patients received a leaflet that explained nurses holding powers, and the unit's key card system. It emphasised the potential safety implications for other patients that were detained, should they leave the unit without staff knowing. Informal patients knew that they could leave the unit freely.

Qualified nursing staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice; 94% of nursing staff had completed their training.

Support workers did not receive specific training in the Mental Health Act. Staff said they discussed the Mental Health Act during mandatory Mental Capacity Act training. Support workers understood the purpose and implications of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrator was and were able to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

On **Kemp unit** staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

All staff had had training in the Mental Capacity Act and deprivation of liberty safeguards and 83% of staff had completed this.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

On **Naomi unit** staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. 83% off all staff had completed training in the Mental Capacity Act. Staff knew how to access the provider's policy.

Detailed findings from this inspection

Staff assumed capacity but described signs that they would look for if they had concerns. During the inspection all patients were assessed as having capacity. Staff assessed capacity on admission and patients consented to treatment including medicines.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Specialist eating disorder services	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

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

Summary of findings

We rated safe as **inadequate** because:

- The unit did not have enough nurses to meet the needs of the patients. Staffing numbers met the establishment levels however patients told us escorted leave and activities were cancelled or rearranged and post therapy support was not always offered. The unit did not monitor this.
- The service did not meet its safeguarding responsibilities. Staff training on how to recognise abuse was not role dependant and did not meet the requirements specified in intercollegiate guidance. Staff raised safeguarding concerns with the hospital's social worker who worked part time. Some staff could could not confirm what process to follow when the social worker was absent.
- The provider did not meet all its duties regarding fire safety. They had identified that the landlord had missed 11 fire alarm tests between March 2019 and October 2019. There were no records prior to 20 February 2019. Fire certificates seen at the inspection were over a year old and had a note saying these had been requested from the landlord. Updated fire certificates were provided after the inspection.

However:

- The unit was clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff had access to clinical information and they maintained high quality electronic clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The unit had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

- The service had access to the full range of specialists required to meet the needs of patients on the unit. Managers made sure they had staff with a range of skills needed to provide high quality care.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The unit had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Support workers did not receive formal Mental Health Act training.
- Capacity to consent to treatment was not easy to locate on the patient record system.

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

- Feedback from patients and family members was mixed. Some people told us that the unit had staffing issues which led to cancelled post therapy support, activities and leave. They felt that not all staff treated patients with dignity and respect.
- Patients did not always feel able to approach staff.
- There was a lack of information on the unit to inform carers of their rights.

However:

- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

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

- The unit did not provide the least restrictive environment possible in order to facilitate patients' recovery. The unit applied blanket restrictions which were not indicated on their blanket restrictions register. Patients could not access the laundry room, sensory room or snug without staff supervision.
- Patients could not decide where they wanted to eat their meals and managers were not able to justify why this were necessary.

However:

- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

We rated well-led as **requires improvement** because:

- Our findings from the other key questions demonstrated that governance processes did not always operate effectively. We identified issues with staffing levels, safeguarding, appraisals, blanket restrictions, fire safety and occupational health and safety monitoring.
- Leaders had not included all restrictions on their blanket restrictions register and therefore we could not be assured if they had been identified and reviewed.
- We found that fire safety and health and safety management was being assessed and monitored. Where there were issues with the management and records we did not see evidence that this was being actioned or improved.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

- Not all staff felt respected, supported and valued.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Are long stay or rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

The ward was clean, well equipped, well furnished, well maintained and fit for purpose. However, we had concerns about the management of fire risks.

Safety of the ward layout

The service did not meet all its duties regarding fire safety. We reviewed documentation and saw the landlord had missed 11 fire alarm tests between March and October 2019. The fire alarm was to be tested weekly. Additionally, there were no records from when the provider took over on 1 January 2019 until 20 February 2019. Fire certificates provided during the inspection were over a year old and a note explaining more recent ones had been requested from the landlord of the site. Following the inspection, the provider sent us an updated emergency lighting periodic inspection and testing certificate dated 2 December 2019 and a copy of the Fire Detection and Alarm System - Maintenance Test Certificate dated 11 November 2019.

However, staff did regular risk assessments of the care environment including identifying any potential ligature anchor points. The most recent ligature risk assessment had been completed in August 2019. A ligature point is anything which could be used to attach a cord for the purpose of hanging or strangulation. The ward layout allowed staff to observe most parts of ward although there were areas that a patient could not be seen. Kemp unit had mitigated the risks adequately by ensuring glass vision panels on bedroom doors, anti-ligature furniture in bedrooms and regular zonal observations of patients were carried out. There were door top alarms on doors in isolated places however due to unreliability these were being decommissioned. The provider had used the door top alarms in addition to risk assessments, care plans and supportive observations when risks were considered high for a patient, however at the time of inspection management had not made a decision in relation to future risk management following the decommission of the door top alarms. Areas with more significant risk such as the

'brew up' and the skills kitchen were accessed using a fob which patients were risk assessed to use. The ward complied with guidance on eliminating mixed-sex accommodation.

Staff had easy access to alarms and patients had access to a nurse call system which we observed to be installed throughout the building.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly and we spoke to the housekeeper during our visit who worked for an external company.

Staff adhered to infection control principles, including handwashing. The provider had an infection control policy, 75% of staff attended infection control training and the provider monitored training compliance.

Clinic room and equipment

The unit had a clinic room where medicines were stored and dispensed from and a fully equipped treatment room on the unit. The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date.

Safe staffing

The service did not have enough nursing staff on the unit to meet the needs of all the patients however staff received basic training to keep people safe from avoidable harm.

Nursing staff

Managers had calculated the number and grade of nurses and healthcare assistants required. When occupancy was greater than four patients the providers safe staffing levels were two nurses and four support workers on days and one nurse and three support workers on nights. We reviewed five weeks staffing rotas and although staffing met the minimum establishment numbers, this was not always enough to fully support patients. During inspection we observed staff from Kemp Unit helping to cover another unit. This was not recorded or monitored by the provider.

The service had high and increasing vacancy rates for qualified nurses.

The provider submitted reporting data for the period 1 May 2019 to 31 July 2019.

- Establishment levels: registered nurses (WTE) - 8
- Establishment levels: support workers (WTE) – 16.6
- Number of vacancies: registered nurses (WTE) – 2.76
- Number of vacancies: support workers (WTE) – 0.6
- The number of shifts* filled by bank or agency staff to cover sickness, absence or vacancies - 276
- The number of shifts* NOT filled by bank or agency staff where there was sickness, absence or vacancies – 14

We requested additional staffing data following the inspection because the deputy unit manager told us that vacancies had increased in two staff groups.

- Number of vacancies: registered nurses (WTE) – 5
- Number of vacancies: support workers (WTE) – 2
- The number of shifts* filled by bank or agency staff to cover sickness, absence or vacancies (1 August to 31 October) – 285
- The number of shifts* NOT filled by bank or agency staff where there was sickness, absence or vacancies (1 August to 31 October) – 10

We spoke with four patients and two family members. Two patients we spoke with and one family member raised concerns in relation to staffing on the unit. The concerns raised related to cancelled leave and activities. During inspection we asked managers about monitoring of cancelled leave or activities, but this information could not be provided. Two patients we spoke with told us that there sometimes wasn't enough staff to support them in their post therapy sessions and patients felt they couldn't approach staff because they were too busy. We looked at unit manager meeting minutes from November 2019 which showed that it had been agreed to use an extra member of staff on therapy days to ensure this support was provided in the future. During inspection there were extra staff allocated as they were expecting to transfer a patient, however, in the meantime the extra staff would have been available to cover the post therapy support sessions.

To cover these vacancies and when additional staff were required managers deployed agency staff to maintain safe staffing levels, however, staff from all professions confirmed there was a shortage of qualified nurses. Staff said that staffing levels were manageable when there were no unforeseen incidents or additional observations in place however one incident had occurred the week before

inspection and staff told us that staffing mix on this day had not been able to meet patient needs and had contributed to the incident escalating. Managers informed us that the staffing mix was considered, and patients and family members informed us that they had raised this with the provider. However, due to a high use of agency and cover arrangements at the time of inspection, we were not assured that the measures in place would prevent this situation from occurring again.

The provider also submitted reporting data for the period 1 January 2019 to 31 July 2019.

- Staff sickness rate (%) – 4.9%
- The number of staff leavers – 7
- Staff turnover rate (%) – 23.2%

The service used contracted agency staff to meet their minimum staffing requirements. Agency staff completed an induction checklist and attended some unit specific training so that they were familiar with the unit and the patients.

The unit manager could adjust staffing levels according to the needs of the patients by using regular staff or agency staff when available. We observed during inspection that staffing levels were increased according to individual patient's needs, for example if a patient required enhanced observations or additional support, extra staff would be brought in to accommodate this. During inspection the number of staff exceeded the staffing requirement due to the individual needs of the patients. There were two nurses and five support workers during the day and one nurse and five support workers during the night.

During inspection a qualified nurse was present in communal areas of the ward at all times.

During inspection we looked at six patient records and observed that staffing levels allowed patients to have regular one-to-one time with their named nurse.

Physical interventions were rarely used on the unit and the hospital had an identified response team for each shift. 85% of staff had been trained to carry out physical interventions safely.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in a psychiatric emergency. The responsible clinician told us that on call doctors used online prescribing and sign off on any emergency section 17 leave online also. For medical emergencies staff used the on-call provision with additional advice from NHS out of hours, emergency services or attended accident and emergency. Staff we spoke to were positive about the medical support available.

Mandatory training

Staff had received and were up to date with appropriate mandatory training.

Overall, staff in this service had 87% compliance of the 19 various elements of training that the provider had set as mandatory. Three courses were below the organisational target of 80%. These were basic life support at 76%, information governance at 79% and infection control at 74%. Managers monitored mandatory training, alerted staff when this needed updating and training was discussed at team meetings. We saw that 94% of qualified nursing staff had completed immediate life support training. Agency staff records indicated that agency staff had the equivalent training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

During inspection we examined six care records and found a comprehensive risk assessment was completed for every patient on admission using a recognised risk assessment tool, the functional analysis of care environments risk profile. The risk assessment was updated regularly, including after any incident.

Management of patient risk

Staff were aware of and dealt with any specific risk issues and completed risk assessments specific to individuals, such as a risk assessment completed for a volunteering opportunity for a patient.

Staff identified and responded to changing risks to, or posed by, patients and developed risk management plans for specific issues such as self-harming behaviour and self-administration of medication.

Staff followed good policies and procedures for use of observation to ensure the least restrictive option and for searching patients or their bedroom which was done collaboratively with patients being present.

Staff applied some blanket restrictions on patients' freedom within the unit environment. Access to some rooms such as the skills kitchen and 'brew up' room were individually risk assessed for access however we observed that all patients had supervised access to the laundry room, sensory room and a room referred to as the snug. We were told that this was due to the location of these rooms within the unit. Five of the patients on Kemp Unit during our visit were informal patients and their fob access allowed them to leave the building however the unit had a clear policy in relation to patients checking in with staff before leaving the unit. This was set out in Kemp unit programme expectations and patients agreed to this during admission.

Use of restrictive interventions

In the 6 months before the inspection to 31/08/19 Kemp Unit provided the information below relating to use of restrictive interventions.

Number of incidents of use of seclusion in last 6 months – 0

Number of incidents of use of long-term segregation in last 6 months – 0

Number of incidents of use of restraint in last 6 months – 63

Of those incidents of restraint, number of incidents of restraint that were in the prone position – 7

Number of (incidents) use of rapid tranquilisation – 1

The majority of the 63 episodes of restraint were concentrated on one patient and all incidents of prone restraint were limited to the same patient who chose to go to the floor in a forward-facing manner during restraint. On every occasion the patient was supported to turn over as soon as safely possible. Although all staff were trained in the use of prone restraint the unit encouraged a culture where this intervention was avoided unless absolutely necessary. All staff we spoke to told us that restraint was rarely used and the staff team worked well to limit the use of restraint.

The unit did not have a seclusion room. The provider reported zero incidents of seclusion or long-term segregation between 1 March 2019 and 31 August 2019.

The provider had a reducing restrictive practice strategy and action plan. The provider became a member of the Restraint Reduction Network in July 2019. Patients had individualised behaviour support plans in place aimed at reducing the need for the use of restraint. When de-escalation had failed, and restraint techniques were required they were used for the shortest time possible, the staff used correct techniques and took an approach which posed the least risk to staff and patients. Staff completed a record of all interventions which contained all relevant information relating to the incident and visual physical health observations when staff were unable to complete the national early warning scores.

Safeguarding

The service did not meet their safeguarding responsibilities and managers were unclear of their obligations. However, staff described how to protect patients from abuse and the service shared this information with other agencies. Staff had training on how to recognise and report abuse, and they knew how to apply it. However, the level of training was not appropriate for all roles.

Staff received training on how to recognise and report abuse but this was not always appropriate for their role. The safeguarding lead had the appropriate level of training for safeguarding adults (levels three and four) but they did not have the appropriate level of children's safeguarding training. All staff, including clinical staff, completed level two safeguarding adults and children's training. Compliance was 83% and 88% respectively. This level of training did not meet intercollegiate guidance for safeguarding children and adults for all staff roles.

Additionally, we saw in meeting minutes that managers in the service had agreed that safeguarding children training was not relevant to the hospital, but then reintroduced level two training later in the year.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff described how they contacted the provider's social worker for advice, who was the safeguarding lead. The social worker then raised safeguarding concerns with the appropriate local authority. However, the social worker worked part time and held many responsibilities within the organisation. Some staff could not confirm the arrangements in place to support staff when the social worker was unavailable. The social worker told us that there are safeguarding alert forms and managers on call in her absence. Following the inspection the provider shared the service's safeguarding flowchart that detailed what to do when the social worker was not available.

However, during inspection the staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service worked in partnership with other agencies such as the local safeguarding team, GP surgery, advocacy and the patient's carers or families.

Staff followed safe procedures for children visiting the unit. The provider had a policy for child protection and child visiting. Visitors did not visit patients on the unit but had access to a visitor's room within the building.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records which were comprehensive.

Staff used an electronic patient record system. All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form.

When patients transferred to a new team, there were no delays in staff accessing their records and information was shared appropriately.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed good practice in medicines management (that is, transport, storage, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance.

Nurses attended medicines training with the provider and had their administration competency assessed annually or following a medication error.

Medicines including controlled drugs and those requiring refrigeration were stored securely within their recommended temperature range.

Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Nurses carried out a nightly audit to ensure checks are being completed and a medicines management audit was undertaken on Kemp unit monthly as part of the clinical audit programme. Action plans were implemented to address any issues identified.

Track record on safety

The service had a good track record on safety.

The service reported no serious incidents in the last 12 months. During inspection we examined four incidents that, in line with the providers incident policy, required a formal review. We examined four investigation reports which included identifying a root cause, lessons learnt and recommendations. We also saw evidence of sharing the outcome of investigations with staff in a sharing the learning bulletin that the provider produced.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff we spoke to knew what incidents to report and how to report them. For example we saw incidents reported relating to medication errors, self-harm, staffing and buildings and premises issues were recorded by staff and investigated and reviewed by the managers in the hospital.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. A carer we spoke to told us that they had been informed when an incident occurred and commented that this was well managed.

Staff received feedback from investigation of incidents, both internal and external to the service via a bi-monthly 'sharing the learning' document which was circulated to the whole staff team, individual supervision sessions, daily staff protected time, which is used for case-based formulation and group supervision staff skills, and during fortnightly business meetings. There was evidence that changes had been made as a result of feedback such as introduction of a medicines error protocol. If there was a medicines error the staff would write a reflective statement and the provider would check competencies and put appropriate action in place such as supervision, training, buddying up with another member of staff or remove keys if not improving.

Staff were debriefed and received support after a serious incident. The unit also adopted a mandatory 15 minute debrief session at the end of every shift for staff to reflect and offload.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

During inspection we viewed six care records. Staff completed a comprehensive mental health assessment of the patient in a timely manner soon after admission.

The service had an effective working relationship with a local GP surgery who assessed patients' physical health needs within 24-48 hours of admission. Staff developed support plans that met the needs identified during assessment and these plans were personalised, holistic and recovery-orientated. The six care records looked at included areas such as mental and physical health, relationships, creativity, medication and discharge planning. The same domains would be discussed during care programme approach meetings and then the plans would be updated as required and necessary.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

During inspection we viewed six care records which all demonstrated good practice in the areas reported on below.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Staff used recognised rating scales and theories to assess and record severity and outcomes such as health of the nation outcome scales, national early warning scores, affect control theory and interpersonal psychotherapy rating scale. The occupational therapy team used the model of human occupation screening tool to assess patients occupational functioning and the dietician used several scales such as body dysmorphic scale, eating disorder questionnaire and compulsive exercise test.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Within the six care records viewed we saw evidence of professional involvement from occupational therapy, psychology, physiotherapy and dietician.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration where relevant and referred to the dietician.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff supported patients to live healthier lives. Kemp unit employed a nurse associate to undertake physical health checks, liaise with GP practices and hold teaching sessions on healthy diets and living skills. Patients are encouraged and supported to access leisure facilities in the community and patients can be supported with smoking cessation whilst on Kemp unit.

Staff participated in regular clinical audits including monthly quality reports, a monthly audit of the care plans to ensure review of risk assessment and support plans were being undertaken, monthly defensible documentation audit, quarterly personal details audit, monthly medication management assessment audit, quarterly controlled drugs audit and environmental audits.

Skilled staff to deliver care

Kemp unit included or had access to the full range of specialists required to meet the needs of patients on the unit. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, Kemp unit employed an occupational therapist and occupational therapy assistants, clinical psychologists, assistant psychologists, a social worker, dietician, physiotherapist, nurses associate and support workers.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group, for example staff undertook training in dissociative identity disorder and interpersonal therapy training. This training was also offered to regular agency workers.

Managers provided new staff with appropriate induction which included an induction for new agency workers provided on their first shift with the hospital. Agency files and profiles included disclosure and barring certificates which were checked monthly, training and their nursing and midwifery council pin, where relevant.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and the percentage of staff that received regular supervision was 83%.

Staff had an annual review of their work performance in the form of an appraisal. The percentage of staff that had had an appraisal in the last 12 months was 34%. The provider's leadership team had agreed a new approach to undertaking staff appraisals and developed a plan to review the appraisal policy, procedure and toolkit in July 2019. Appraisal training was developed and bespoke sessions delivered to managers so they were trained in undertaking appraisals. The provider told us all existing staff would be appraised by the end of December 2019. All new staff, appointed since 1st January 2019, completed a probationary review, and an appraisal 12 months after they were confirmed in post.

Managers ensured that staff had access to regular team meetings. All staff attended business meetings every fortnight and staff had an hour protected time daily for group supervision, staff skills or formulation. A monthly staff forum had been established and we observed minutes of the last meeting. A monthly bulletin was produced by the leadership team to give staff an update on bed occupancy and waiting lists, extracurricular activities such as the Christmas party or sponsored walk, updates from the staff forum and staff wellbeing news. The provider also produced a bi-monthly sharing the learning bulletin.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.

Managers ensured that staff received the necessary specialist training for their roles. The responsible clinician ran dissociative identify disorder training every three months and interpersonal therapy training was delivered to staff. Staff we spoke with were attending training in trauma risk management. This training is trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event.

Managers dealt with poor staff performance promptly and effectively ranging from issues regarding infection control or management of documents to suspending of staff following complaints or safeguarding concerns.

Multi-disciplinary and inter-agency team work

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular and effective multidisciplinary meetings. Kemp unit held weekly clinical team meetings in relation to patients on the unit. Multidisciplinary meetings would be held every four to six weeks with a care programme approach meeting in-between. During inspection we attended a care programme approach meeting and observed them to be well structured. The meeting was attended by the patient, nursing staff, occupational therapy, social worker, psychology and consultant. The external home team could not attend so a speaker phone was used to involve them in the meeting. The patients' needs were considered. Outcome measures were discussed, risk, medication, therapy sessions and goals were reviewed. Physical health was discussed and relevant external referrals. Discharge and funding were discussed, and forward planning identified.

Staff shared information about patients at effective handover meetings within the team and within a daily 'report out' meeting which was attended by the consultant, nurses and support workers. We observed the report out to be patient focussed, we observed evidence of collaborative work with external agencies, physical health consideration and introduction of recovery dogs for trauma based on evidence from a research pilot.

The ward teams worked hard to establish effective working relationships with teams outside the organisation, for example, clinical commissioning groups, GPs, commissioners and independent advocacy service.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Nursing staff were trained in and those we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. 94% of nursing staff had had training in the Mental Health Act. The provider told us that the rest of the staff team gained some basic understanding during other training such as mandatory Mental Capacity Act training.

Staff had easy access to administrative support on site for advice on implementation of the Mental Health Act and its Code of Practice, patients' detention papers and associated records were securely stored with the administrator and copies were scanned onto the patient electronic record system.

The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice via the intranet.

Patients had easy access to information about independent mental health advocacy. The local independent advocacy service visited the service. Staff would support patients where necessary to access the service, advocates were invited to attend multi-disciplinary and care programme approach meetings for the individual patients. Posters for the service were on notice boards and leaflets available for patients and their carers and families.

Staff explained to patients their rights under the Mental Health Act, repeated it as required and recorded that they had done it. During inspection there were two patients detained under the Mental Health Act and their rights were explained in a way that they could understand.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. There was a separate file for section 17 leave for detained patients and available to all staff that needed access to them. It was clear on the forms when and what the purpose of the leave was for. Staff assessed patients prior to their leave and evaluated on return. The service displayed a notice to tell informal patients that they could leave the ward freely however all patients were risk assessed prior to leaving the unit.

Staff requested an opinion from a second opinion appointed doctor when necessary. The detained patients Mental Health Act paperwork and prescriptions corresponded.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

All staff had had training in the Mental Capacity Act and deprivation of liberty safeguards and 83% of staff had completed and staff we spoke to showed a good understanding of the Mental Capacity Act, in particular the five statutory principles.

There were no patients subject to a deprivation of liberty safeguards which is an application made to the local authority to protect patients without capacity to make decisions about their own care.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff took all practical steps to enable patients to make their own decisions. For patients who might have impaired mental capacity, staff assessed and recorded this, however, during inspection we found it wasn't easy to find the recording of capacity to consent on the electronic patient record system. Staff explained to us that they would not accept decisions made whilst a patient was in a dissociative state and if patients needed to access medical treatment staff would support them. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff made these decisions in their best interests. A best interest meeting would be held and within this meeting staff would recognise the importance of the person's wishes, feelings, culture and history.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Feedback from some patients and family members indicated that not all staff treated patients with dignity and respect. However, staff we spoke with understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke to four patients and two family members and feedback was mixed. Some people told us that staffing was an issue which led to a lack of post therapy support, cancelled activities and leave. Some people raised concerns about the staff mix and this issue also led to the escalation of a patient incident, despite staff understanding of patient needs and triggers.

All patients raised concerns in relation to the food provided on the unit, they told us it was awful, food would go missing or the correct food did not arrive, therefore most patients self-catered. Patients also raised an issue regarding where they could eat their food. The provider imposed a blanket restriction which meant that all meals had to be eaten in the dining room. During inspection the provider was unable to give a clear explanation or rationale regarding this restriction.

However, some patients told us that staff treated them well and behaved appropriately towards them, patients were positive about the interpersonal therapy provided and their involvement in service provision. One family member we spoke to told us that the staff were excellent, warm, nurturing and caring, even during difficult times.

Staff supported patients to understand and manage their care, treatment or condition. The provider had produced a comprehensive patient information guide which explained the unit team, programme, unit facilities and programme expectations, however during inspection some patients told us that they were confused by some of these

expectations and had spoken to staff in the community business meeting to have these clarified. Staff told us they were working on a new document with patient involvement.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. We saw evidence that patients were referred to other services when appropriate such as advocacy, GP, dentist and referrals to specialists such as orthotics.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. We observed the provider using of the preferred pronouns for patients and consideration of needs from the LGBT+ community.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients. The provider undertook a defensible documentation audit monthly to ensure good communication and record keeping.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had access to independent advocates.

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Patients referred would have a pre-admission assessment and tour of the environment. The unit had patient mentors allocated to new patients to support with settling into Kemp unit and answering questions about the unit.

Staff involved patients in care planning and risk assessment and during inspection we examined six care records which evidenced this such as patient views clearly documented and care plans written by patients. Patients would attend multidisciplinary and care programme approach meetings to discuss their care, treatment and discharge plans. Patients were encouraged by staff to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. The unit specialised in supporting patients with dissociative identity disorder which is a mental illness characterised by at least two distinct and relatively enduring personality states. This is accompanied by memory gaps. Plans were in place to support staff to communicate with the different identities such as alphabet cards to use when patients have difficulties communicating.

Staff involved patients in decisions about the service, through fortnightly community business meetings, care planning and in the recruitment and training of staff. Patients could give feedback on the service during these community meetings and through other methods such as comments boxes, friends and family test and complaints process.

Staff ensured that patients could access advocacy.

Involvement of families and carers

Staff informed and involved families and carers appropriately where patients consented to this involvement. Where families and carers were involved staff provided them with support when needed.

Family members we spoke with told us that they had complained to the provider and also that the provider had responded to these concerns. Where a family member made a formal complaint the unit investigated this.

If carers or family members requested information about how to access a carer's assessment we were told they would be referred to the social worker, who was the carers lead, however, the social worker worked part time and had various roles within the service. Carers may not be aware that they are entitled to this assessment and therefore would not know to ask. We did not see any literature for carers or a carers welcome pack on the unit which would provide them with this information.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Requires improvement

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Discharge was rarely delayed for other than a clinical reason.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Discharge was reviewed at multidisciplinary meetings and care program approach reviews. The expected length of stay was between six months and two years. The average length of stay of patients discharged in the last 12 months, as reported by the provider was 296 days.

All patients currently accessing the service were out-of-area placements. The unit was a national specialist service that provided assessment and treatment based on a two-year programme. Beds were available when needed for patients living in the 'catchment area' due to occupancy levels.

There was always a bed available when patients returned from leave.

When patients were moved or discharged, this happened at an appropriate time of day and was well planned.

A bed would be sourced in a psychiatric intensive care unit (PICU) if a patient required more intensive care and the provider would try and ensure this was sufficiently close for the person to maintain contact with family and friends.

Discharge and transfers of care

The service had no delayed discharges between 1 January 2019 and 31 August 2019.

In the last 12 months, the provider did not report any delayed discharges from the unit. Staff carefully planned for patients' discharge, including good liaison with case managers and care co-ordinators to make sure this went well.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. During inspection one patient was being moved to a psychiatric intensive care unit with ongoing support from a nurse, therapist and consultant from Kemp unit.

The facilities promote recovery, comfort, dignity and confidentiality

The layout of the unit did not always fully promote recovery and independence. Patients did not have access to the laundry, sensory room or snug without staff supervision. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food provided was not of good quality however patients had access to hot drinks and snacks at any time and staff supported patients to self-cater.

Patients had their own ensuite bedrooms and could personalise their bedrooms which we observed during inspection. Patients had a key to their rooms, somewhere secure to store their possessions and if patients were being supported to self-medicate there was also a lockable section within a secure drawer to hold their medication.

There was a range of rooms for patients but not all of these were accessible. Patients were individually risk assessed to access such rooms such as the 'brew up', skills kitchen and dining room however other rooms, such as the laundry, sensory room and snug were not freely accessible to any patients due to their location on the unit and therefore did not promote recovery and independence of patients. In addition to this patients told us that they had to eat all their meals in the dining room. When we spoke to the provider there was not a clear rationale as to why this was the case and it was not included on the unit's blanket restrictions register. The provider was aware that patients were unhappy with this arrangement and were looking to review the situation.

Staff had access to a full range of rooms and equipment to support treatment and care such as a clinic room and treatment room to examine patients, activity and therapy rooms, communal lounge and skills kitchen. Patients had risk assessed access to outside space.

There were quiet areas on the unit and a room off the unit, within the main building where patients could meet visitors.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Patients could make a phone call in private and had access to their own electronic devices.

Six out of seven of the patients self-catered. Patients told us that the food provided was not of a good quality. Patients were individually risk assessed to access the 'brew up' room, dining room and skills kitchen and those patients who did not have unsupervised access to these rooms told us that hot drinks or snacks would be made available for them as required.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. The service also supported and saw the benefit of animals and pets in people's lives and in supporting patients recovery and one patient had her own rabbits in the garden of the unit and looked after these during her stay.

When appropriate, staff ensured that patients had access to education and work opportunities. One patient used their occupational therapy budget so that they were able to pay for transport to attend a voluntary job in the community.

Staff supported patients to maintain contact with their families and carers where this was appropriate for the individual.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients. However, staff helped patients with communication, advocacy and cultural and spiritual support.

During inspection we received feedback from some patients and family members who told us that not all patient needs were being met due to issues with staffing and staff mix. These issues led to the escalation of an incident, cancelled post therapy support, activities and leave. Patients also told us that catering on the unit was of poor quality, food ordered would not be provided and would go missing.

However the unit was on the ground floor and therefore accessible for disabled patients. Kemp unit also met any communication needs such as interpreters and staff were also able to access training in British Sign Language.

Kemp unit had several leaflets and information accessible for all patients. A welcome booklet provided patients with information on the unit team, programme, unit facilities and programme expectations. We saw a leaflet for informal patients which included information about patients' rights, observations, right to vote, complaints and advocacy.

The information provided was in a form accessible to the particular patient group and could be provided in an easy read format or in a different language if required. This would be identified as part of the preadmission process. During inspection we were told that the occupational therapy team were designing leaflets and booklets in different fonts and coloured papers to support those patients with dyslexia.

We were told that the kitchen would be able to provide a choice of food to meet the dietary requirements of religious and ethnic groups. However, patients told us that the food was not of a good quality and six of the patients chose to self-cater which was positive for their rehabilitation and independence however this may not be appropriate for all patients.

Staff ensured that patients had access to appropriate spiritual support and the unit had provision for patients who required this either within the service or in the community. A support worker volunteered their time every Saturday to give holy communion to those patients who wished to take part.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Kemp Unit reported two complaints in last 12 months and both of these complaints were partially upheld. No complaints had been referred to the Ombudsman in last 12 months.

Patients knew how to complain or raise concerns. This information was contained within the welcome pack that patients were given, leaflets were available and feedback was encouraged through community meetings, surveys and comments boxes on the unit.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

When patients complained or raised concerns they were handled appropriately by the staff and patients received feedback. We looked at minutes of community meetings where actions from the previous meeting were discussed.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care. They understood the service they managed. Patients and staff knew who they were and could approach them with any concerns.

Leaders were visible in the service and approachable for patients and staff. Patients and staff we spoke to knew who the managers and senior managers were and saw them on the unit.

Leadership development opportunities were available, including opportunities for staff below team manager level. Some support workers had dual roles such as assistant psychologist and the nursing associate had been a support worker at the service for several years before being given the opportunity to progress. Development for nursing staff was also considered such as nurse prescribing and psychotherapy training.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The new provider had taken over in January 2019 and at the beginning of the year all staff attended a workshop around engaging staff, developing the culture and exploring the values of the organisation.

The provider agreed a preferred communication method with staff and produced a bulletin which we saw evidence of during inspection. The provider also introduced a people strategy.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider told us that earlier in the year they held team away days centred around exploring how their values are embedded, explored collaboration, the patient handbook and the unit pathways. The provider told us that they have also incorporated values into their recruitment process.

The provider planned to build a new hospital on the grounds of their current premises. The plan was subject to planning permission; the provider submitted a planning application which was going through due process. Staff were informed about the service's future and progress made.

Culture

Staff did not always feel respected, supported or valued, however, most of the staff we spoke with told us they could raise concerns without fear. They felt the service provided opportunities for career development.

The provider used staff surveys to get feedback from staff including the friends and family test and culture of care barometer. Hospital wide, 29 of 66 staff responded to the culture of care barometer in September 2019. Results in some areas were negative with a percentage of staff in some areas choosing to neither agree or disagree:

- 52% of respondents would not recommend Schoen Clinic – York as a good place to work and 10% responded 'neither'
- 48% of respondents felt they were unable to influence how things were done and 28% responded 'neither'
- 48% of respondents felt their team was not well managed and 28% responded 'neither'
- 48% of respondents felt uninformed about what was happening in their team and 28% responded 'neither'
- 48% of respondents felt there was not strong leadership at senior leadership levels and 31% responded 'neither'

Results were positive in terms of friendliness of colleagues (83%), reliability of colleagues when things were difficult (69%) and feeling respected by co-workers (76%).

The provider responded to the results and implemented a plan that was actioned and updated. They established a monthly staff forum, introduced a freedom to speak up guardian and progressed the staff mental health and wellbeing plan. Managers reviewed communication methods for staff such as monthly staff bulletins, introduced a comments box and a 'you said, we did' board for staff. The provider set up a staff tuck shop and used an honesty box so that staff could buy snacks and drinks. Managers external and internal to the service also set up drop in sessions for staff.

During inspection most of the staff we spoke to told us that they felt able to raise concerns without fear of retribution, they knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian.

Managers dealt with poor staff performance when needed. Teams worked well together and where there were difficulties staff we spoke to felt managers dealt with them appropriately.

The staff appraisals process had been updated in July and planned that all staff who were with the service from January 2019 would have an appraisal by December 2019. At the time of inspection 34% of staff on Kemp Unit had an appraisal. It was unlikely that the further 66% of staff would have an appraisal completed within the month following inspection. However, the new appraisals process included conversations about career development and how it could be supported.

The service's staff sickness and absence on 31 July 2019 was at 4.9%. Staff had access to support for their own physical and emotional health needs through an occupational health service. The unit also held debrief sessions at the end of each shift to support staff and had a mental health and wellbeing strategy in place. There was an employee assistance line for staff and a poster in the staff office informing staff of therapies available to them.

Staff were able to raise concerns and feedback service improvement ideas. The service had a people strategy and the clinical leadership team had put a proposal forward to the management team regarding ideas for staff recognition.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service, but these were not always effective.

Kemp unit had structures, processes and systems in place but these were not always effective.

The service did not meet their safeguarding responsibilities and managers were unclear of their obligations. Safeguarding training did not meet intercollegiate guidance and staff were unclear of the safeguarding process when the part time social worker was unavailable. The social worker also had no clinical supervisor to support them.

The action plan relating to staff appraisals was not being closely managed. Kemp unit was unlikely to meet its appraisals target to have all staff appraisals competed by December 2019. On 26 November 2019 only 34% of staff that worked on Kemp unit had received their annual appraisal.

Managers had not identified all blanket restrictions on the unit. A register of blanket restrictions was in place on Kemp unit. The provider told us this was to ensure that all restrictions are known about, justified, proportionate and reviewed quarterly in governance meetings however some room restrictions and the dining room restriction was not on the register. The provider had identified these areas as higher risk due to the location of the areas and the items within them however we were concerned that these were not being assessed and reviewed to ensure they were proportionate and justified.

The service did not meet all its duties regarding fire safety and occupational health and safety. Fire alarm tests had been identified as being missed by the landlord, but we had no assurance that action had been taken by the provider to resolve this.

After issuing our draft report the Schoen Clinic provided emails to show that requests had been made to the landlord regarding test certificates and missed fire alarm tests. The provider informed us they are trying to establish a more effective relationship with the landlord.

The service had an action plan for occupational health and safety, and although many actions had progressed there were also outstanding actions that had passed the 'completed by' date. The July 2019 action plan identified that Display Screen Equipment assessments hadn't been completed for all users and by November only three staff had completed this. Following the inspection, we were told that all other staff were booked for their assessment in

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

December 2019 or January 2020. The service identified on 1 July 2019 that it had no asbestos policy and in November the policy was in draft form. We received an approved asbestos policy dated 3 December 2019.

At the time of inspection Kemp unit had door top alarms in situ to mitigate the risks in isolated places on the unit. There was an incident earlier in the year when a door top alarm did not sound, and continued unreliability of these alarms had led to them being decommissioned. The provider had used the door top alarms in addition to risk assessments, care plans and supportive observations when risks were considered high for a patient, however at the time of inspection management had not made a decision in relation to future risk management following the decommission of the door top alarms.

However, there were systems and procedures in place to ensure that wards were safe and clean and that patients were assessed and treated well. The provider committed to reducing restrictive interventions and patients had clear care plans and behaviour support plans which identified individual needs and triggers and patients were involved in creating these. Monthly audits were in place to monitor care plans and the quality of patient records.

A monthly quality report was produced by the quality manager using information collected from unit-based activity and documented a review of incidents, CQC notifications, investigations, safeguarding, restraint, incidents and complaints. This report would be shared at leadership team meetings and shared with the staff team through several communication methods. There was a clear framework of what must be discussed at all levels in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. We saw evidence that staff implemented recommendations from audits, investigations and reviews following incidents, complaints and safeguarding alerts.

Managers and staff ensured that the service adhered to the Mental Health Act and Mental Capacity Act and that referrals, admissions and discharges were planned and well managed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Staff maintained and had access to the risk register at unit level and staff were reminded at team meetings how to access it. Staff on Kemp unit level could escalate concerns when required. The risk register was accessible to all staff via the incident reporting system. Staff concerns matched those on the risk register. Risks on both the local and corporate registers related to the recruitment of qualified nurses, legionella, information technology infrastructure and employee engagement.

The service had plans for emergencies and implemented these when needed.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work, however some staff told us that the equipment required updating and it is not always easy to get information technology support. The deputy unit manager informed us that funding was in place to update the equipment in the near future.

Information governance systems included confidentiality of patient records and the service undertook audits and fed this back to the teams.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed such as the Care Quality Commission and local safeguarding teams.

Engagement

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the intranet, bulletins and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients had different methods and channels they could give feedback such as morning meetings, community meetings, comments boxes and surveys. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Patients requested attendance from a local therapeutic animal charity which was facilitated. Prior to inspection we received positive feedback from this external provider. Patients also requested a printer which we saw during our inspection.

Patients and carers were involved in decision-making about changes to the service. Patients told us how they had been involved in staff recruitment, including interviews, training and staff inductions.

Patients and staff could meet with members of the provider's senior leadership team to give feedback. Senior managers held drop in sessions that staff and patients were invited to attend.

Directorate leaders engaged with external stakeholders such as commissioners and Healthwatch. NHS England staff regularly attended referrals meetings and community mental health teams attended or dialled into care programme approach meetings. The responsible clinician also met with NHS organisations to develop models of care and pathways for patients with complex mental health problems such as dissociative identity disorder and also to develop clear co-ordination for patients discharge particularly where there were safeguarding concerns relating to a patient's local area.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff talked about submitting business proposals to the leadership team in terms of occupational therapy and staff rewards and recognition. Staff told us they were kept up to date and involved with the plans for the new build hospital.

The responsible clinician told us that the unit had been monitoring the use of interpersonal therapy with patients over three years and was writing a qualitative paper on this. The service was also working with NHS England in terms of establishing a clear pathway and model for the service type. The doctors and allied health professionals attended professional conferences relevant to their roles and the patient group.

Innovations were taking place in the service. The occupational therapy team introduced an ecotherapy group, a term for treatment programmes which aim to improve mental and physical wellbeing through doing outdoor activities in nature. The group endeavoured to assist with grounding patients using fresh air and creative expression.

Staff used quality improvement methods such as audit tools and outcome measures for patients which were presented at meetings and reviewed.

Staff participated in audits and reviews relevant to the service and learned from them. The unit had two external reviews which provided recommendations for the service, however one review was prior to the new provider taking over in 2019.

The unit did not currently participate in an accreditation schemes due to difficulties finding ones that were relevant to the service however we were told on inspection that the service was signing up to the royal college of psychiatrist's standards for inpatient mental health rehabilitation services.

Requires improvement

Specialist eating disorder services

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

Summary of findings

We rated safe as **inadequate** because:

- The service did not have enough nursing staff to meet the needs of all patients. Staffing levels met the establishment levels but these were not sufficient when the unit was at full capacity and accepting new admissions. The provider did not always meet the minimum staffing levels or have enough staff to cover all patient observations or facilitate group sessions. Trips out were cancelled or rearranged. Some patients did not always feel able to approach staff for support.
- The service did not meet its safeguarding responsibilities. Staff training on how to recognise abuse was not role dependant and did not meet the requirements specified in best practice guidance. This included safeguarding children's training for the social worker who was the safeguarding lead. Staff raised safeguarding concerns with the hospital's social worker who worked part time. Some staff could not confirm what process to follow when the social worker was absent.
- Staff followed the previous provider's engagement and observation policy while waiting on the ratification of the new provider's policy in December 2019.
- The provider did not meet all its duties regarding fire safety. They had identified that they had missed 11 fire alarm tests between March 2019 and October 2019. There were no records prior to 20 February 2019. Fire certificates seen at the inspection were over a year old and had a note saying these had been requested from the landlord. Updated fire certificates were provided after the inspection.
- Patients had restricted access to the laundry facilities and accessible toilet. Staff could not justify this restriction for informal patients who were identified as a lower risk of harm. Although staff would provide disabled patients with a key to the accessible toilet on the unit, managers had not identified the bathroom being locked, as a restriction on the register.

However;

- The unit was clean, well equipped, well-furnished and well maintained.
- The service had enough doctors and allied health professionals. All staff knew the patients well and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed clinical risks to patients. They achieved the right balance between maintaining safety and providing the least restrictive environment possible, to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used low levels of restraint.
- Staff had easy access to clinical information and they maintained high quality clinical records, both paper-based and electronic.

Requires improvement

Specialist eating disorder services

- The service used systems and processes to safely prescribe, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.
- The unit had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills, and meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and benchmarking.
- The unit team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The unit team had effective working relationships with other staff from services that would provide aftercare following the patient's discharge. Staff engaged with other providers early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However;

- Some staff were not supported with appraisals, supervision and there were limited opportunities for staff to update and further develop their skills. The social worker, who was also the safeguarding lead, had no clinical supervisor. None of the qualified nursing staff had received any external training in the past 11 months. Support workers did not receive formal Mental Health Act training and 69% of staff that worked on the unit had not received their annual appraisal.

We rated caring as **good** because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff ensured that families and carers were fully involved in care. The service provided family therapy sessions and held collaborative carers workshops to enhance their skills, knowledge and confidence in supporting someone with an eating disorder.

However;

Requires improvement

Specialist eating disorder services

- Some patients did not always feel able to approach staff.
- Privacy and dignity were not always ensured. Patients signed up to book appointments with staff on the 'opt in' board in the main corridor. This meant that other patients and visitors were able to see what patients were attending.
- The Naomi unit guide referred to the previous provider. Some items recorded in the documents were no longer applicable.

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

- The layout of the unit did not fully ensure patients' privacy and dignity. Staff measured patients' blood pressure on the corridor in front of other patients, visitors and staff. Patients were weighed in the small clinic room because it was more accessible that the treatment room.
- The pathways to recovery document referred to the previous provider and did not fully reflect the current service provided.

However;

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The unit met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

We rated well-led as **requires improvement** because:

- Staff did not all feel respected, supported and valued by their leaders. The provider had no leadership development or additional training for qualified nurses. However, leaders had implemented a plan to address poor staff morale that was actioned and updated.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively. We identified issues with staffing levels, safeguarding, appraisals and development, blanket restrictions, frequency of team meetings, monitoring checks in the corridor, fire safety and occupational health and safety.
- Staff struggled to describe innovations that were taking place in the service or quality improvement methods that they were involved in.

However;

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt positive and proud about their team, the care they provided and the programme. Most staff felt able to raise concerns without fear of retribution.

Requires improvement

Specialist eating disorder services

Are specialist eating disorder services safe?

Inadequate

Safe and clean environment

The unit was clean, well equipped, well-furnished and well maintained.

Safety of the unit layout

Staff completed and regularly updated thorough risk assessments of all unit areas and removed or reduced any risks they identified. Although there were potential ligature anchor points in the service, staff knew where these were and mitigated the risks to keep patients safe. Staff used observations to keep patients safe and where there were blind spots the service had installed mirrors. Staff described and complied with the observation policy of the previous provider. Schoen Clinic York's supportive observation and engagement policy was due to be approved on 12 December 2019. The unit only admitted women so there was no mixed sex accommodation. Staff had easy access to alarms and patients had easy access to nurse call systems. These were tested regularly.

However, the service did not meet all its duties regarding fire safety. The fire alarm was to be tested weekly by the hospital's landlord. We reviewed documentation and saw the unit had missed 11 fire alarm tests between March and October 2019. Additionally, there were no records from when the provider took over on 1 January 2019 until 20 February 2019 and no record of a fire drill on 9 September 2019. Fire certificates provided during the inspection were over a year old and a note explaining more recent ones had been requested from the landlord of the site. Following the inspection, the provider sent us an updated emergency lighting periodic inspection and testing certificate dated 2 December 2019 and a copy of the Fire Detection and Alarm System - Maintenance Test Certificate dated 11 November 2019.

After issuing our draft report to the service, managers provided emails to evidence requests to the landlord regarding fire safety, including test certificates and missed fire alarm tests. However, it is the responsibility of the provider to ensure that subcontracted services are delivered in an appropriate manner.

Maintenance, cleanliness and infection control

Unit areas were clean, homely, well maintained and well-furnished. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

The hospital had detected legionella in routine sampling. They closed Naomi unit from 23 May 2019 to 1 July 2019 to prevent patients becoming unwell. On 2 July 2019 Naomi unit reopened to patients in an alternative location in the hospital. We reviewed documentation and saw that the service had thorough ongoing checks in place and that staff were well informed during and following the outbreak.

Clinic room and equipment

The unit had a clinic room where medicines were stored and dispensed from, and a fully equipped treatment room off the unit. Resuscitation equipment including defibrillator was stored in the nursing office. Night staff followed the organisation's audit schedule to check, maintain, and clean equipment.

The unit had immediate access to emergency medicines to treat anaphylaxis and hypoglycaemia in line with their organisational policy.

Safe staffing

There was not enough staff on the unit to meet the needs of all the patients. However, staff in the service knew patients well and received basic training to keep people safe from avoidable harm.

Nursing staff

Managers had calculated the number and grade of nurses and support workers required, in line with their safe staffing levels policy. However, this was not enough to deliver care and treatment to the patients on the unit.

When there were zero to nine patients on the unit, the minimum staffing requirements were two qualified nurses and two support workers on day shift, and one qualified nurse and two support workers at night. For ten to 15 patients on the unit, staffing increased by one extra support worker on the day shift. The unit had increased its admissions between 30 September 2019 and 18 November 2019 from nine to 15. Although staffing met the minimum establishment numbers; this was not enough to fully

support patients. We saw staff from another unit covering observations. This was not recorded or monitored by the provider, so they could not identify if there were additional staffing needs on Naomi unit.

We spoke with six patients and three carers or family members, and all spoke of short staffing on the unit. Although the service used agency staff, staff from all professions confirmed there was a shortage of qualified nurses. Patients held an emergency meeting on 15 November 2019 to discuss staffing issues and the impact this had on their recovery, particularly when the unit was at maximum capacity. Some patients did not always feel able to approach staff for support.

Patients, families and some staff described how meals out or activities had been cancelled or rearranged due to staffing availability. We saw that a group that should have been delivered by two staff was delivered by one. We reviewed five weeks staffing rotas. There was one occasion where the qualified nursing establishment was not met. Between January and the end of November the unit logged 18 uncovered shifts. Some patients required a staff escort to leave the unit due to risks from physical health and this could not always be accommodated. The provider's purging protocol specifies that patients must be accompanied for the first two weeks of admission when off the unit and staffing had not increased above the establishment levels when the unit admitted new patients.

Staff said that staffing levels were manageable when there were no unforeseen incidents or additional observations in place. However, staff on the unit had reported four incidents when they were unable to get cover from the other unit or agency.

The provider submitted reporting data for the period 1 May 2019 to 31 July 2019.

- Establishment levels: registered nurses (WTE) - 8
- Establishment levels: support workers (WTE) – 14.1
- Number of vacancies: registered nurses (WTE) – 1.43
- Number of vacancies: support workers (WTE) – 2.1
- The number of shifts* filled by bank or agency staff to cover sickness, absence or vacancies - 24
- The number of shifts* NOT filled by bank or agency staff where there was sickness, absence or vacancies – 3

We requested additional staffing data following the inspection because Naomi unit was closed 23 May 2019 to 1 July 2019. The provider reported an increase in vacancies in two staff groups. They had three whole time equivalent qualified nursing vacancies and three and a half whole time equivalent support worker vacancies.

The provider also submitted reporting data for the period 1 January 2019 to 31 July 2019.

- Staff sickness rate (%) – 6.7
- The number of staff leavers – 7
- Staff turnover rate (%) - 21.9%

Staff sickness rates were reducing. During the inspection sickness rates had dropped to 5.6%

The unit had a high turnover of staff. Many staff transferred to work for Schoen Clinic - York when the previous provider stopped delivering inpatient services. Staff had left for a variety of reasons, including to work with different patient groups, to take retirement or because they wanted to work for other organisations.

The service used agency staff on short term contracts to meet their minimum staffing requirements and cover vacancies. Agency staff completed an induction checklist and attended some unit specific training so that they were familiar with the programme and patients. However, staff needed to fully understand the unit's pathways to recovery programme to deliver care effectively and this was challenging without permanent staff. Some staff said that there had been an improvement since agency staff were contracted and were key working with patients. Managers tried to ensure that there was a mix of agency and permanent staff on shift.

The unit manager could adjust staffing levels according to the needs of the patients by offering regular staff overtime, and using bank and agency staff. However, staff were not always available to cover additional needs or staff sickness. Between 1 January 2019 and 26 November 2019, the service reported 272 shifts filled by agency staff; 217 qualified nurse shifts and 55 support worker shifts. There were 18 uncovered shifts in this period.

Supernumerary staff including the multidisciplinary team members and managers had supported with observations on shifts or planned activities such as baking.

Patients confirmed they had regular one to one sessions with their named nurse. We saw sessions recorded in five of the six care records we viewed.

Physical interventions were rarely used on the unit and the hospital had an identified response team for each shift.

Staff shared key information to keep patients safe when handing over their care to others. Staff had detailed handovers that identified risks, strengths and needs of all the patients.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the unit quickly in an emergency. All staff and patients spoke highly of the medical team on the unit. On call was shared equally amongst the medical team. Managers also used locums when they needed additional medical cover, for example, for planned leave.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Training was available as e-learning with some courses delivered face to face. Managers monitored mandatory training and alerted staff when they needed to update their training; training was discussed at team meetings. Overall, staff in this service had undertaken 87% of the 19 training courses that the provider had set as mandatory. Three courses were below the organisational target of 80%. These were basic life support at 76%, information governance at 79% and infection control at 74%. We identified no issues in these areas during the inspection. We saw that 94% of qualified nursing staff had completed immediate life support training. Agency staff records indicated that agency staff had the equivalent training. The staff board in the nursing office and handover notes also identified who the immediate responder was on each shift.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used de-escalation techniques to avoid the use of restraint. The service did not seclude patients. The unit staff participated in the provider's restrictive interventions reduction program.

Assessment of patient risk

We reviewed six care records and saw that staff completed risk assessments for each patient on admission using a recognised tool. Risks included self-harm, substance abuse or aggressive behaviour. Risk assessments were reviewed and updated regularly, including after incidents.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. We saw care plans updated and comprehensive handovers that highlighted patient risks and strengths.

Staff followed procedures to minimise risks where they could not easily observe patients. They had recently introduced zonal observations as the least restrictive way of managing patients that needed increased support.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff described searching patient's belongings on admission and searching bedrooms with patients present. Search procedures were explained to patients prior to their admission in the welcome pack.

Staff were aware of and dealt with any specific risk issues, such as falls or hazards from showering. The service had not implemented a smoke-free policy. Patients could smoke in the courtyard outside.

During the inspection, all patients were informal and could leave at will. They had key card access to ensure unrestricted access. Staff asked that patients let them know where they were going and for how long. There was no curfew in the service.

There were two blanket restrictions in place. The first was access to the laundry room. This room was identified on the blanket restriction register and ligature audit. Patients had to be accompanied to this room because of risks posed by the environment. The laundry room was located off the unit. All patients were informal but had not been individually assessed to use this room. The second was an accessible toilet on the unit. This had not been identified on the blanket restriction register. Staff confirmed that if a patient needed access they would provide them with a key. Patients had access to en-suite bathrooms so alternative bathrooms were accessible.

Use of restrictive interventions

Levels of restrictive interventions were low, and staff worked well to limit them. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Naomi unit reported zero restraints and rapid tranquilisations between 1 March 2019 and 31 August 2019. This reporting period included 23 May 2019 to 1 July 2019 when the unit was closed. Staff were able to describe National Institute for Health and Care Excellence guidance for the use of rapid tranquilisation. Staff and patients confirmed that restraint was not used on the unit. Staff gave clear examples of de-escalation techniques and knew the patients well. They worked with patients to identify triggers and crisis plans. Staff described how they avoided trigger words, how different staff would respond to patients and how they would encourage patients to alternative areas on the unit. The unit had put up a small tent in the lounge so that patients could have somewhere quiet and safe to use instead of their bedrooms.

The unit did not have a seclusion room. The provider reported zero incidents of seclusion or long-term segregation between 1 March 2019 and 31 August 2019.

Schoen Clinic UK was a member of the Restraint Reduction Network since 9 July 2019 and the provider had a reducing restrictive practices strategy and action plan that to the reflected the 'No Force First' initiative.

There was a hospital wide rapid response team. Staff that were part of this team were identified on the staff duty board and at handover.

Safeguarding

The service did not meet their safeguarding responsibilities and managers were unclear of their obligations. Staff described how to protect patients from abuse and the service shared this information with other agencies. Staff had training on how to recognise and report abuse, and they knew how to apply it. However, the level of training was not appropriate for all roles.

The service did not meet their safeguarding responsibilities and managers were unclear of their obligations. Staff received training on how to recognise and report abuse but this was not always appropriate for their role. Although the safeguarding lead had the appropriate level of training for safeguarding adults, (levels three and four), they did not have the appropriate level of children's safeguarding training. Neither did other clinical staff in the unit. All staff completed level two safeguarding adults and children's training. Compliance was 83% and 88% respectively. This level of training did not meet Inter Collegiate guidance for safeguarding children and adults.

Additionally, we saw in meeting minutes that managers in the service had agreed that safeguarding children training was not mandatory for the hospital because they had no young patients. They then reintroduced level one and two training later in the year.

Staff described how they contacted the provider's social worker for advice who then raised safeguardings with the appropriate local authority. However, the social worker worked part time and held many responsibilities within the organisation. Some staff could not confirm if there were alternative arrangements in place when the social worker was unavailable, on leave or unwell. Some staff said if needed, they would speak with the unit manager or raise the concern with the local authority themselves. Following the inspection the provider shared the service's safeguarding flowchart that detailed what to do when the social worker was not available.

However, staff were able to describe how to recognise adults and children at risk of or suffering harm.

Staff followed clear procedures to keep children visiting the unit safe. Patients used a comfortable family room off the unit.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They gave examples of making reasonable adjustments for patients with additional needs and considered religious beliefs, physical needs and communication needs.

The unit raised no safeguarding concerns with the CQC between 01 January 2019 and 31 October 2019.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, and all staff, including agency, could access them easily. The provider used a secure electronic record keeping system for patient records. The unit also kept an at a glance folder for key information. These reflected current patient care needs.

Paper records such as physiotherapy assessments were also scanned and uploaded to the electronic record keeping system. This was well managed; there was no delay in accessing additional information.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients were normally discharged to community mental health teams and information was shared appropriately.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health. However staffing levels impacted on the timely administration of medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, the service had recently changed pharmacy providers, so nine of the patients' medicines charts, were recorded on the previous provider's charts. New charts were to be used for all new admissions and for any current patients whose charts ran out. All medicines policies and documentation with pharmacy contact details had been updated.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients were given leaflets and were able to speak with the doctor about their medicines. Doctors were available out of hours to initiate pain relief if required. Patients described the doctors as approachable and felt comfortable speaking with them. Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. All staff were able to access the pharmacy's online system and a pharmacy technician or pharmacist attended the unit every week to check medicines cards and provide any updates. Staff completed annual medicines competencies and if there were errors in medicines practice, managers followed internal procedures to support staff in their learning and keep patients safe. Seven support workers were trained to countersign and check controlled drugs.

Staff reported medicines errors on the provider incident reporting system and we saw learning fed back from these.

Monthly audits were completed that included patient details, recording omissions, security of cupboards and fridges, fridge and room temperatures and the management of controlled drugs. In addition, nursing staff completed weekly checks of controlled drugs.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines were reviewed weekly at the multidisciplinary meeting.

Staff reviewed the effects of each patient's medicines on their physical health according to The National Institute for Health and Care Excellence guidance. Staff described increasing physical observations and discussing side effects with patients.

Track record on safety

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had a good track record on safety.

Between 1 March 2019 and 31 August 2019, the provider reported zero serious incidents.

The provider had an outbreak of legionella which closed Naomi unit from 23 May 2019 to 1 July 2019. The provider informed all the appropriate agencies and kept patients, families and staff well informed.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. For example, incidents relating to self-harm, staffing and buildings and premises were recorded by staff and investigated and reviewed by the managers in the hospital. All incidents received a 72-hour review by a manager where actions were recorded. Incidents were risk rated using a scoring matrix and included a review for any duty of candour incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff completed duty of candour training during their induction. There were posters reminding staff of their responsibilities in the staff

office. Duty of candour was recorded on the incident reporting system. We saw evidence that the organisation had apologised for the interrupted treatment and disruption following the detection of legionella.

Staff received feedback from investigation of incidents, both internal and external to the service.

An automated summary report of all incidents within the previous 24 hrs across the hospital was sent out each morning to the wider managerial and clinical team. Every two months managers produced a 'Sharing the Learning' document which was circulated to the whole staff team. This showed incident reports and/or investigations completed and identified any changes to practice and lessons learned. Staff described improvements regarding water testing after the legionella outbreak with clearer roles and responsibilities. Staff met to discuss the feedback and look at improvements to patient care. They also described improvements in practice across the hospital following an increased use of restraint on another unit.

Managers debriefed and supported staff after any serious incident. The provider had extended each shift handover by 15 minutes to include a daily debrief session. Additional debriefs were also facilitated by an external psychologist from a neighbouring healthcare provider.

The service had no never events. Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

From the point of referral, staff in the service assessed patients' needs. Staff held effective multidisciplinary referrals meetings that considered all aspects of patient care. The service sought feedback and information from patients and their families and carers, GPs and other healthcare professionals. Staff also discussed the equipment needs for the admission and patient risks.

Staff completed a health and social assessment that was fully aligned with the therapeutic programme delivered by the unit. Staff assessed all patients' personal and social history, psychological needs, behaviours, capacity, mental health, physical health, activities of daily living and life skills, interpersonal relationships, social circumstances and response to care.

Patients attended the unit or the local physical health hospital for physical health assessment prior to admission. Once they had successfully completed the assessment process, they would be offered a date for admission.

Staff completed a comprehensive mental health assessment and physical assessment of each patient on admission. Patients had physical checks completed every four hours when first admitted. Physical health was also regularly reviewed throughout the admission.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed six care plans that were all personalised, holistic and recovery-oriented. Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and benchmarking activities.

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance for example, from relevant bodies such as The National Institute for Health and Care Excellence. The service was a modified therapeutic community. This meant that the social relationships, the structured daily programme and different activities were deliberately designed to help the patients'

health, well-being and recovery. The service developed the Pathways to Recovery programme which used Cognitive Behavioural Therapy to help patients to understand and change their behaviours.

The programme consisted of seven pathways; psychological, meaningful living, physical activity, physical monitoring, meaningful eating, self-catering and leave pathways. Each pathway consisted of multiple steps. Initially, the programme reduced the patient's physical risk and enabled them to gain basic skills in each of the pathways. Patients then gained advanced skills and transferred these skills to use in everyday life and upon discharge. Patients set care and treatment goals to achieve throughout and following their admission. Initially short term goals were set to ensure the patients were physically well, and additional goals were then identified and reviewed in line with the pathways through to discharge. The electronic record system allowed staff to record and monitor patients' progress through the programme.

Staff identified patients' physical health needs and recorded them in their care plans. Staff regularly recorded patient's blood pressure and weight. Staff used the Modified Early Warning Score (MEWS) to assess and monitor patients' physical health and we saw additional information such as physiotherapy assessments attached to patients records.

Staff made sure patients had access to physical health care, including specialists as required.

In addition to the two doctors, qualified nurses, dietician and physiotherapists in the service, patients attended appointments on and off the unit with a local GP and advance nurse practitioner. Smoking cessation advice was provided by the advance nurse practitioner.

Patients also attended the local physical health hospital for any specialist appointments.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The programme included compulsory groups such as shop and cook, and life skills, that were led by the occupational therapy team and nursing staff. There were also additional optional groups such as swimming, yoga, gardening and the gym.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients attended groups and appointments with the service's dietician and nutrition support worker. There were post meal support groups throughout the day and a supported drinks group.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scales to measure the health and social functioning of patients, and the Yale–Brown Obsessive Compulsive Scale to rate the severity of obsessive–compulsive disorder symptoms. The programme encouraged patients to reflect on their personal progress and to review how these linked to their personal recovery goals. Patients prepared for their care programme approach meetings and trips out by identifying how they were progressing on each pathway.

Staff did not use technology to support patients. Staff said that this was an area they hoped to develop.

Staff took part in clinical audits and benchmarking activities. Staff completed audits of medicines, the Mental Health Act, infection control and care records. Managers used results from audits to make improvements. Audits identified who to contact to ensure actions were completed. For example, night staff raised low stock or upcoming expiry dated with the clinical manager.

Skilled staff to deliver care

The unit team included or had access to the full range of specialists required to meet the needs of patients on the unit. Managers made sure they had recruited staff with the range of skills needed to provide care. Managers provided an induction program for new staff and most staff received regular supervision. However, they did not always support staff with appraisals, team meetings or opportunities to update and further develop their skills.

The service had a full range of specialists to meet the needs of the patients on the unit. This included psychiatrists, qualified nurses, nursing assistants, dieticians, social workers, psychologists, physiotherapists, occupational therapists and a cognitive behavioural therapist.

Managers recruited staff with the right skills, qualifications and experience to care for patients. Managers gave each new member of staff a full induction to the service before they started work. Staff completed e-learning training modules, attended the provider induction, received

specialist eating disorder training led by the unit psychiatrist and shadowed other staff and meetings on the unit. Contracted agency staff completed a similar induction programme and induction checklist.

All nurses had received clinical supervision and 83% of nurses had management supervision. Support workers received only management supervision but could access the daily debrief sessions at handovers. 79% of support workers had received management supervision. Except for the social worker and physiotherapist, all allied health professionals that worked for the organisation, received clinical supervision from within their own profession via peer group supervision or one to one supervision. As an interim measure the physiotherapist received clinical supervision from the consultant psychiatrist. However, the social worker, who was also the safeguarding lead, received only managerial supervision.

Managers did not support all staff through yearly, constructive appraisals of their work. The provider implemented a new staff appraisal system that aligned to the organisational values in July 2019. Managers planned for all staff to have a completed appraisal by the end of December, but this target was unlikely to be met. During the inspection only 31% of staff that worked on the unit had received their annual appraisal. Managers reviewed new members of staff throughout their probationary period.

Managers did not ensure all staff groups received additional specialist training for their role. Allied health professionals, doctors and some managers received external training relevant to their role. However, qualified nurses and support workers did not. Three support workers from the staff team had attended additional training. One attended a phlebotomy (blood taking) course, one a course on wound care, and another trained to be a prevention management of violence and aggression trainer. Three support workers and one qualified nurse had attended a conference. No qualified nurses had received any external training.

Staff did not attend regular team meetings. Team meetings were arranged for every other week. We requested the last three meeting minutes and saw that between the period 23 September 2019 and 26 November 2019, only two of the six team meetings occurred. Meetings followed a standardised agenda and clear meeting minutes were recorded and shared.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The unit team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. We observed staff discussing all aspects of care for every patient. When allied health professionals were unable to attend they provided a report which was discussed as a team.

Staff made sure they shared clear information about patients and any changes in their care at handover meetings and multidisciplinary meetings. During multidisciplinary meetings staff recorded notes that were available to all staff. Clear handover notes included input throughout the day from all staff groups.

Unit teams had effective working relationships with other teams in the organisation. Staff from another unit supported where possible when patient needs increased.

Unit teams had effective working relationships with external teams and organisations. Staff from NHS England attended referrals meetings and care co-ordinators and community mental health team staff attended care programme approach meetings. When external colleagues could not attend meetings in person, staff arranged teleconferences to ensure patients had good quality care during and after their admission. One community mental health team fed back positively about the care given, programme and staff. Staff also worked closely with the local GP surgery and local physical health hospital.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Qualified nursing staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice; 94% of nursing staff had completed their training. Although support workers did not receive specific

training in the Mental Health Act, staff said they discussed the Act during mandatory Mental Capacity Act training. Support workers understood the purpose and implications of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrator was and were able to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. There was information on boards and advocate details were visible in patient records.

During the inspection there were no detained patients on the unit. Informal patients knew that they could leave the unit freely and patients had key card access.

Staff explained patients their informal rights. A leaflet was also provided to patients in the welcome pack. The leaflet explained nurses holding powers, and the unit's key card system. It emphasised the potential safety implications for other patients that were detained, should they leave the unit without staff knowing.

We reviewed patient records and saw that staff had previously explained patients their rights under the Mental Health Act. Staff requested an opinion from a Second Opinion Appointed Doctor when needed and we saw an approved mental health professional report in patient records for patients that had previously been detained. Staff stored copies of patients' detention papers and associated records correctly and could access them when needed.

Care plans included information about after-care services available to patients who qualified for it under section 117 of the Mental Health Act. Aftercare and discharge arrangements were discussed at regular care program approach meetings. Patients met with their community team prior to discharge.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded patient capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. 83% off all staff had completed training in the Mental Capacity Act. There was also a provider policy, which staff knew how to access.

Staff assumed capacity but described signs that they would look for if they had concerns. During the inspection all patients were assessed as having capacity. Staff assessed capacity on admission and patients consented to treatment including medicines. We saw capacity recorded in patient records and at multidisciplinary meetings.

The service monitored how well it followed the Mental Capacity Act. Compliance to the Mental Capacity Act was monitored as part of the manager's audit program.

Are specialist eating disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice. However, patients shared that they did not always feel able to approach all staff for help due to staff being busy or stressed. One patient said that staff spent a lot of time in the office completing paperwork.

Staff supported patients to understand and manage their own care, treatment or condition. The therapeutic programme was based on cognitive behavioural therapy that helped patients to understand and change their behaviours. For example, patients completed meaningful living reviews prior to trips out. These helped to identify strategies regarding meals and focused on how the trip linked to their recovery goals.

Staff directed patients to other services and supported them to access those services if they needed help. Patients attended relevant charity groups in York and were encouraged to attend recovery colleges in their local area as part of their relapse plans.

Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient. Staff knew patients well and were considerate when talking about them or to them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. The therapeutic community worked together to resolve any issues within the patient group.

Staff followed policy to keep patient records confidential. However, in the main corridor there was an 'opt in' board to book appointments with staff. This meant that other patients and visitors were able to see what the patients were attending.

Involvement in care

Staff involved patients, families and carers in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

We spoke with six patients using the service and received two comments cards. All spoke positively about staff and the program.

Staff introduced patients to the unit and the services as part of their admission. Patients received a detailed welcome pack that described staff roles, the programme and the unit. However, the pack still referenced items that were applicable to the previous provider such as the previous provider's chaplain and some facilities. Staff also described taking photographs of one patient's prospective bedroom and floorplan to help them prepare for their admission.

Staff involved patients and gave them access to their care planning and risk assessments. All records had personalised information and goals. Patients also attended multidisciplinary team reviews and were asked if they wanted a copy of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff described how they would repeat information, use photographs or images and simplify language and terms used.

Staff involved patients in decisions about the service. The service was in the process of reviewing the care programme and held focus groups with patients to gather feedback. Patients were also involved in making amendments to the welcome pack.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had multiple opportunities to feedback on the programme. They held business meetings and called emergency meetings that all members of the therapeutic community were expected to attend. The service had a feedback box and the unit manager held weekly drop-in sessions for patients. Patients were also asked to complete patient surveys. They had a 'you said, we did' board to ensure patients knew how issues were being responded to, and a comments book to discuss any issues relating to the meals provided. All patients said they felt able to feedback about the service and treatment.

Patients knew how to access advocacy services for additional support. There were posters and details available on the unit.

Staff supported patients to make advanced decisions on their care. Patients completed a 'respect my wishes' document that identified their personal preferences for care.

Involvement of families and carers

Staff supported, informed and involved families or carers. We spoke with three carers or family members and all felt involved in their relative's care. They said that they could see progress being made by their relative.

Families and carers were involved from preadmission to discharge. Staff contacted families and carers before the admission, invited them to care programme approach meetings and telephoned them to provide updates. They received a copy of the unit welcome pack. Families were well informed and understood the care programme that their family members were completing.

The service held a collaborative carers workshop, twice a year, for families and carers. The two day course was

facilitated by the consultant psychiatrist, cognitive behavioural therapist and assistant psychologist. The workshop aimed to enhance families and carers skills, knowledge and confidence in supporting someone with an eating disorder. Families and carers also attended family therapy sessions.

Staff helped families to give feedback on the service. Families and carers completed questionnaires and spoke with the unit's carers champion. Families also said they felt able to telephone the service.

Staff said that the social worker gave carers information on carer's assessments.

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

Requires improvement

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Staff identified a provisional date for discharge on admission which was reviewed at multidisciplinary meetings and care programme approach reviews. The expected length of stay was between six and 12 months. The length of stay reported by the provider was 210 days.

The unit was a national service that prioritised patients in the local area. Following the temporary closure of the Naomi unit there had been an increase in the number of days between referral to assessment (26) and initial assessment to treatment (25).

Staff considered seasonal pressures when planning admissions. During a referral meeting they anticipated an increased need over the Christmas period and reviewed upcoming admissions.

Staff always ensured that when patients went on leave they returned to their own bedrooms and that when patients were discharged it was at an appropriate time of day for the patient.

The provider could arrange a transfer of care to a psychiatric intensive care unit if a patient needed more intensive care, however this had never been necessary.

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff held regular meetings in person and by phone. Patients and families met with their community mental health teams before discharge to ensure patients were supported throughout the transition.

The service had no delayed discharges between 1 January 2019 and 31 August 2019.

The facilities promote recovery, comfort, dignity and confidentiality

The layout of the unit did not fully ensure patients' privacy and dignity. Staff measured patients' blood pressure in the corridor in front of other patients, visitors and staff. Patients were weighed in the small clinic room because it was more accessible. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. They had a locked drawer in their rooms and a key to their bedrooms.

Staff used a full range of rooms and equipment to support treatment and care including therapy kitchen, clinic room and group and individual therapy rooms. The unit also had a fully equipped treatment room off the unit. However, staff did not always use this to weigh patients or to complete blood pressure checks. Instead they used the clinic room and corridor. Staff said this was because some checks were completed too frequently to use the treatment room and there was no waiting area for patients that might need a seat. However, this did not respect the privacy and dignity of the patients.

The service had quiet areas and a room where patients could meet with visitors in private. Staff had also set up a small tent in the lounge that patients could use for additional privacy. Patients could make phone calls in private and could access outside space easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. The meaningful living pathway promoted engagement. Patients identified and reconnected with leisure activities, studies and spiritual needs to help them in their recovery. Staff encouraged patients to attend recovery colleges in their local area and work as volunteers in local organisations.

Staff helped patients to stay in contact with families and carers. Visitors were welcome on the unit, and families and carers were invited to attend meetings with their loved ones.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service supported and made adjustments for disabled people and those with communication needs or other specific requirements. Patients in wheelchairs could access all areas and staff considered all of their needs. For example, following a discussion with one patient, the service ensured there was additional space to hang out washing on the clothes lines. Staff described making reasonable adjustments for patients. This included considering patients sensory needs, allowing autistic patients to speak first in group activities and allowing extra time or making changes to written exercises for dyslexic patients.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Patients received a detailed information pack and there was information displayed on the unit in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed. Patients had access to spiritual, religious and cultural support if they wished.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Menus rotated every three weeks and there was a comments book to gather feedback on the quality of food.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

All patients, relatives and carers said they would be able to raise issues with staff in the unit. Most patients, relatives and carers knew how to complain or raise concerns formally. The unit had leaflets about how to complain in patient areas and a comments box. The unit welcome pack included complaints details.

Staff understood the policy on complaints and knew how to handle them. They would attempt to resolve the complaint locally and would also escalate complaints. There had been one formal complaint from a patient on Naomi Unit between 1 January 2019 and 31 July 2019. The complaint related to the flexibility of the programme but was not upheld.

Managers investigated complaints and identified themes. They reported on and shared information with staff, the senior leadership team and NHS England who commissioned the service. Patients received feedback from managers after the investigation into their complaint.

Following a complaint, managers sent a short survey to the complainant to get their views on the experience and whether they were satisfied with the process.

Managers shared feedback from complaints and learning was used to improve the service. For example, patients fed back about food being cold and staff arranged an additional trolley to keep meals warm.

Requires improvement

Specialist eating disorder services

Staff protected patients who raised concerns or complaints from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care. Naomi unit received seven formal compliments between 1 January 2019 and 31 July 2019.

Are specialist eating disorder services well-led?

Requires improvement

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported some staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. Patients and staff knew who the managers and senior managers on site were by name.

The service had some development opportunities available for staff. Some senior support workers had dual roles with additional responsibilities; these included train the trainer, assistant psychology and nutrition support. However, there was no leadership development for qualified nurses.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff had attended a one day workshop that engaged staff and developed the service's culture, vision and values. Values were also incorporated into the recruitment process.

The provider planned to build a new hospital on the grounds of their current premises, subject to planning permission. Staff were informed about the service's future and progress made.

Culture

Staff did not always feel respected, supported or valued. Some staff were cautious to raise concerns for fear of consequences. The service did not provide opportunities for career development to all staff.

Staff did not always feel respected, supported and valued. The provider used staff surveys to get feedback from staff including the friends and family test and culture of care barometer. Hospital wide, 29 of 66 staff responded to the culture of care barometer in September. Results in some areas were poor:

- 74% of respondents would not recommend Schoen Clinic – York as a good place to work
- 70% of respondents felt they were unable to influence how things were done
- 67% of respondents felt their team was not well managed
- 63% of respondents felt uninformed about what was happening in their team
- 68% of respondents felt there was not strong leadership at senior leadership levels

Results were positive in terms of friendliness of colleagues (83%), reliability of colleagues when things were difficult (69%) and feeling respected by co-workers (76%).

The provider responded to the results and implemented a plan that was actioned and updated. They established a staff forum which met monthly, introduced a freedom to speak up guardian and progressed the staff mental health and wellbeing plan. Managers completed a review of salaries, sent monthly staff bulletins and introduced a comments box and 'you said, we did' board for staff. The

provider set up a staff tuck shop and used an honesty box so that staff could buy snacks, drinks and easy meal items like porridge and noodles. Managers external and internal to the service also set up drop in sessions for staff.

During the inspection, staff continued to give mixed feedback, but some acknowledged that managers were attempting to address the cultural issues within the service.

Staff felt positive and proud about their team, the care they provided and the programme. Teams worked well together and where there were interpersonal difficulties or poor staff performance, managers dealt with them appropriately.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Most staff felt able to raise concerns without fear of retribution.

The staff appraisals process had been updated in July. Consequently, the service was not on track to ensure that all staff had received their annual appraisal in the first year of opening. However, the new appraisals process included conversations about career development and how it could be supported. The service's staff sickness and absence rates were also improving.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The unit also held debrief sessions at the end of each shift to support staff and had a mental health and wellbeing strategy in place.

The provider had recently started to recognise staff success within the service. All staff were proud that one of the housekeeping staff had recently been awarded a staff recognition award.

Staff were able to raise concerns and feedback to service improvement. The service had a people strategy and senior leaders of the organisation held discussion groups and drop in sessions for staff.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service, but these were not always effective. Staff received updates to learn from the performance of the service.

The unit had governance processes in place, but these were not always effective.

There were not enough staff in the service to meet the needs of all the patients and this had not been identified by leaders in the organisation. The unit had increased the number of patients on the unit and had not considered additional staffing needs above the establishment levels. This had and continued to impact on staff morale and patient experience.

The service did not meet their safeguarding responsibilities and managers were unclear of their obligations. Safeguarding training did not meet Inter Collegiate guidance and some staff were not clear if the service had a process to raise safeguarding when the part time social worker was unavailable. The social worker also had no clinical supervisor to support them.

Systems and processes relating to staff appraisals and development were not consistently managed for all staff roles. Managers did not ensure all staff groups received additional specialist training for their role. No qualified nurses had received any external training. The service was unlikely to meet its appraisals target to have all staff appraisals competed by December 2019. On 26 November 2019 only 31% of staff that worked on the unit had received their annual appraisal.

Although there was a clear framework of what was to be discussed in team meetings to share essential information, team meetings did not always take place. Between 23 September 2019 and 26 November 2019, only two of the six team meetings occurred.

Systems and processes for monitoring blood pressure and weight did not consider patients' dignity and privacy. Staff took these measurements in clinic room and corridor instead of the treatment room. This had become normal practice.

Managers had not identified all blanket restrictions on the unit and could not justify why these were in place. Informal patients, who were identified as lower risk, had to be escorted to the laundry room because of ligature risks and the accessible toilet was always locked on the unit.

The service did not meet all its duties regarding fire safety and occupational health and safety. Eleven fire alarm tests had been missed over an eight month period. Although managers had attempted to resolve this with the hospital's landlord, missed tests were seen between March and October 2019. Paperwork, including fire certificates were not current during the inspection. The service had an

action plan for occupational health and safety, and although many actions had progressed there were also outstanding actions that had passed the 'completed by' date. The July 2019 plan identified that actions from the workplace health and safety inspections were not being achieved in a timely manner. This was still the case in the November action plan. The July action plan identified that Display Screen Equipment assessments hadn't been completed for all users and by November only three staff had completed this. Following the inspection, we were told that all other staff were booked for their assessment in December 2019 or January 2020. The service identified on 1 July 2019 that it had no asbestos policy and in November the policy was in draft form. We received an approved asbestos policy dated 3 December 2019.

However, there were good systems and procedures to ensure that units were safe and clean and that patients were assessed and treated well. Use of restraint and rapid tranquilisation was rare and patients had crisis and relapse plans that identified triggers and actions. Staff monitored the quality of patient records and there was a clear holistic programme of care that empowered patients to recover.

Information was collected from unit based activity, such as safeguarding, incidents, clinical audit, HR, use of restraint and complaints. This was collated into a quality report and shared at Leadership Team meeting. Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts. The service shared information with staff via email bulletins that included a summary and clear actions.

Staff also undertook or participated in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Managers and staff ensured that the service adhered to the Mental Health Act and Mental Capacity Act and that referrals, admissions and discharges were planned and well managed.

Managers recruited staff with the right skills, qualifications and experience. Each new member of staff had a full induction to the service before they started work.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Staff maintained and had access to the risk register at unit level and staff were reminded at team meetings how to access it. Staff at unit level could escalate concerns when required. The risk register was accessible to all staff via the incident reporting system. Staff concerns matched those on the risk register. Risks on both the local and corporate registers related to the recruitment of qualified nurses, legionella, fire panel and employee engagement.

The service had plans for emergencies and implemented these when needed. The provider successfully implemented the plan when legionella was detected and safely discharged the patients to alternative providers.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service used systems to collect data that were not over-burdensome for frontline staff. The service collected and analysed data relating to performance and care.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff had enough computers to access patient records, but sometimes the equipment was slow to load.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers had weekly meetings to discuss performance, and performance reports were standardised and shared with the senior leadership team. Information was in an accessible format, and was timely, accurate and identified areas for improvement. Managers submitted regular performance data to NHS England.

Staff made notifications to external bodies as needed.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, monthly bulletins and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Comments boxes were available on the unit and the service encouraged patients and families to complete surveys. Patients, families and carers all said they felt able to speak with staff in the unit if they needed to.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Patients and carers were involved in decision-making about changes to the service. The service was redesigning the welcome pack and pathway with patients following feedback they had received.

Patients and staff could meet with members of the provider's senior leadership team to give feedback. Senior managers held drop in sessions that staff and patients were invited to attend.

Leaders engaged with external stakeholders such as commissioners, Healthwatch and other healthcare organisations. NHS England staff regularly attended referrals meetings and community mental health teams attended care program approach meetings. The hospital manager also met with NHS organisations to review and develop models of care for patients with eating disorders.

Learning, continuous improvement and innovation

There was a mixed understanding of quality improvement methods used and few staff were able to describe how the service was continually improving. Staff did not participate in research.

Staff struggled to describe innovations were taking place in the service or quality improvement methods that they were involved in. Staff were not aware of taking part in clinical research. However, staff felt they were able to offer suggestions to improve the service. One member of staff had suggested a self-catering breakfast group that was now in place.

The doctors and allied health professionals attended professional conferences relevant to their roles and the patient group.

The consultant psychiatrist had set up a Marsipan (Management of Really Sick Patients with

Anorexia Nervosa) group and had a special interest in caring for patients with autism. This led to good practice on the unit for patients with autism.

Naomi unit participated in accreditation schemes. The unit had a Quality Network for Eating Disorders (QED) accreditation visit scheduled for 13th December 2019 for Naomi Unit.

Outstanding practice and areas for improvement

Outstanding practice

Kemp Unit

Involvement of patients in care planning, contributing to the unit and feedback on the quality of care provided. Kemp unit promoted patient involvement in all aspects of the service including preadmission, care planning and risk assessments, community business meetings, patient feedback, staff recruitment and training.

Naomi Unit

The service held a collaborative carers workshop, twice a year, for families and carers. The two day course was facilitated by the consultant psychiatrist, cognitive behavioural therapist and assistant psychologist. The workshop aimed to enhance families and carers skills, knowledge and confidence in supporting someone with an eating disorder.

Areas for improvement

Action the provider MUST take to improve

Kemp Unit

- The provider must ensure that there are enough suitably qualified, competent, skilled and experienced staff working on the unit to meet the needs of all patients. The provider must ensure all staff have regular supervision and an annual appraisal. (Regulation 18).
- The provider must ensure that the mandatory training identified is at the appropriate level to support staff to carry out their role safely and effectively. (Regulation 13).
- The provider must ensure they review all restrictions to ensure they are justified and proportionate to enable recovery and independence of patients. (Regulation 10).
- The provider must ensure that they act to improve the service when they assess and monitor the quality and safety of the service provided. The provider must ensure that actions relating to fire safety, occupational health and safety and restrictive practices are completed in a timely way. (Regulation 17).

Naomi Unit

- The provider must ensure that patients' privacy and dignity are always respected on the unit. This includes when measuring blood pressure and weight and when using the sign up board to book appointments.
- The provider must ensure that staff complete the appropriate level of children's and adults safeguarding training specific to their role.
- The provider must ensure that they act to improve the service when they assess and monitor the quality and safety of the service provided. The provider must ensure that actions relating to fire safety, occupational health and safety and restrictive practices are completed in a timely way.
- The provider must ensure that there are enough suitably qualified, competent, skilled and experienced staff working on the unit. All staff must receive the appropriate support, training, professional development, and appraisals to enable them to fully carry out the duties they are employed to perform.

Action the provider SHOULD take to improve

Kemp Unit

- The provider should monitor any cancelled activities and section 17 leave and ensure all patients have access to their leave.
- The provider should review whether all staff have the appropriate training in the Mental Health Act.
- The provider should ensure that all staff understand local safeguarding processes when the safeguarding lead is unavailable.
- The provider should ensure capacity to consent is clearly recorded on the patient record system.
- The provider should ensure they provide written information for carers and family members to inform them of their rights.
- The provider should ensure patients are offered good quality food choices.

Outstanding practice and areas for improvement

- The provider should continue to address the cultural issues within the organisation.
- The provider should ensure an appropriate safety mechanism is in place to mitigate the identified risks of the doors on the unit.

Naomi Unit

- The provider should review whether all staff have the appropriate training in the Mental Health Act.
- The provider should ensure that all staff understand local safeguarding processes when the safeguarding lead is unavailable.
- The provider should ensure all policies and documents used in the organisation reflect the provider's position and the current service being delivered.
- The provider should continue to address the cultural issues within the organisation.
- The provider should ensure that staff from all disciplines receive the appropriate level of supervision to enable them to fully carry out the duties they are employed to perform.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect On **Kemp unit** the provider did not fully promote the recovery and independence of the patients. All patients had supervised access to the laundry room, sensory room and snug due to the location of these rooms. The provider had not recognised these restrictions on their blanket restriction register and therefore there was no oversight to ensure they were proportionate and justified. All patients had to eat their meals in the dining room and managers were not able to justify why this was necessary. **This was a breach of regulation 10(2)(b)** On **Naomi uni**t the provider did not make sure that they treated people using services with dignity and respect or ensure the privacy of the patients using the service. Blood pressure was taken in the corridor in front of patients, staff and visitors. Patients had to sign up on an appointments board that was located in the communal corridor. **This was a breach of regulation 10(2)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have established systems and processes or operate effectively to prevent the abuse of patients. Patients were not protected from abuse and improper treatment in accordance with this regulation.

This section is primarily information for the provider

Requirement notices

Staff training in children's and adults safeguarding was not always appropriate for their role or in line with best practice guidance.

The safeguarding lead did not have the appropriate level of children's safeguarding training for their role.

This was a breach of regulation 13 (1)(2)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider did not introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Managers identified that fire alarm tests had been missed but did not act quickly to resolve this. Paperwork, including fire certificates were not current. The service's occupational health and safety action plan had outstanding actions that had passed the 'completed by' date. Managers had not identified blanket restrictions on the unit and were not able to justify why these were necessary. **This was a breach of regulation 17(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing On **Kemp unit** the provider did not have enough numbers of suitably qualified, competent, skilled and

Requirement notices

experienced persons working on the unit. Staff did not all receive appropriate training, supervision and appraisals to enable them to fully carry out the duties they were employed to perform.

Numbers of staff working on the unit did not meet the needs of patients. Escorted leave, activities and post therapy support were cancelled or rearranged.

Use of agency staff was high but they were not always able to attend when there were gaps in staffing or additional staffing needs. Some staff covered another unit but this was not monitored.

This was a breach of regulation 18(1)(2)(a)

On **Naomi unit** the provider did not have enough numbers of suitably qualified, competent, skilled and experienced persons working on the unit. Staff did not all receive appropriate support, training, professional development and appraisals to enable them to fully carry out the duties they were employed to perform.

Numbers of staff working on the unit did not meet the needs of patients. Activities and trips off the unit were cancelled or rearranged.

Agency staff and staff from another unit were not always able to attend when there were gaps in staffing or additional staffing needs. Ad hoc agency staff did not understand the pathway to recovery program.

Staff were not always able to access additional training, team meetings, supervision or professional development opportunities.

This was a breach of regulation 18(1)(2)(a)