The Retreat - York

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

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

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

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

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

Summary of findings

Overall summary

We rated The Retreat York as requires improvement because:

- We had concerns about medicines management practice. Issues found during the inspection included; staff not recording the reasons for missed doses of medication, medication not being dated when it was opened and medication care plans were not always thorough and updated. Staff did not correctly record the administration of covert medication.
- Appraisal and supervision rates across the organisation were low. This meant that there was a reduced opportunity for staff to learn and develop their skills. Staff told us that they did not feel comfortable in raising concerns to the organisation's senior management due to the historic blame culture in the organisation, although they were optimistic about the new chief executive officer's approach and felt this would improve under their leadership.
- Patients on older people's units had significantly long lengths of stay. On George Jepson unit the average was 6.8 years and on the Katherine Allen unit it was 6.1 years; for some patients, the placement was not appropriate.
- There was one electrocardiograph machine for use by the whole hospital and staff sometimes took this off site to another unit 30 minutes drive away so it was not always available for the monitoring of patient's physical health.
- Units did not staff to establishment levels set by the provider. Activities were cancelled on units and patients told us that staff could not always respond to their requests. Staff told us they did not always receive an induction when they covered shifts on other units and were not familiar with different patient groups' needs.
- Risk assessments were not always completed in line with the provider's policy. They did not always record the action they should take to lessen risk when patients refused physical healthcare checks and they were not completed within the time period in the provider's policy. We found issues with the updating of blood test results in patient records and maintenance of estates not being completed in a timely fashion due to a staffing restructure.
- Dining areas on older people's units and the eating disorder unit were small. There was not enough space for patients at mealtimes with staff supporting patients on units. However a full range of rooms and equipment was available to support patient treatment and care.

However;

- Staff on all units had received training in the Mental Health Act and Mental Capacity Act and showed their knowledge while caring for patients. They kept their understanding and skills up to date by meeting the provider's combined mandatory training target.
- The provider had safeguarding policies and procedures in place and staff knew how to use them and how to report incidents. Staff on all services used restraint as a last resort, and de-escalation techniques were clearly recorded in individual care and treatment plans. Where agency and bank staff were used, the units prioritised the use of familiar staff on the units.
- Staff worked as a multidisciplinary team involving all professionals appropriate to support the patients. Attention to patients' physical health care was also apparent. There was a range of therapeutic activities available on all units; although, on the George Jepson unit we saw limited meaningful engagement when patients were not in scheduled activities.
- There was access to a range of spiritual and faith support hosted by the chaplain who included different patient's faiths into interactions.
- Patients and carers were involved in their care and the running of the service. They told us told us that staff were respectful and polite.
- Staff felt supported by their line managers and spoke positively about them. Staff supported each other and offered help to ensure the best outcome for patients. Staff worked within the values of the provider, and we saw evidence of care provided in line with the organisational values.
- All units were clean and tidy. Where blind spots and ligature points existed, risk had been lessened by the use of zonal observations.

Summary of findings

Contents

Requires improvement

Services we looked at

Wards for older people with mental health problems; Specialist eating disorders services; Specialist personality disorder wards.

Summary of this inspection

Background to The Retreat - York

The Retreat York was established in 1796 and is an independent specialist mental health care provider for treatment of up to 98 people with complex mental health needs. The service is located on a forty acre site on the outskirts of York. The main building is Grade II listed with a range of their buildings situated in the grounds.

The main building consists of six units across three services:

Wards for older people with mental health problems

- George Jepson unit is a 13 bedded unit located on the ground floor that provides specialist care and treatment for men who have a primary diagnosis of a functional or organic disorder such as dementia and other disorders. It supports patients who may have challenging behaviour.
- Katherine Allen unit is a 12 bedded unit situated on the first floor which provides specialist older adult care for women with functional or organic disorders such as depression or psychosis or dementia. It supports patients who may have challenging behaviour.

Specialist eating disorders services

- The Naomi unit is a 15 bedded specialist eating disorder unit for women with complex needs situated on the first floor. The team specialise in treating women with more than one diagnosis, which may include personality disorders, obsessive compulsive disorder and complex post-traumatic stress disorder. Naomi unit is a modified therapeutic community that uses a programme of group and individual therapy to help people take responsibility for their own recovery.

Specialist personality disorder wards

- The Kemp unit is a 10 bedded personality disorder unit for women with severe and complex personality disorder with a focus on borderline personality disorder, dissociation and dissociative identity disorder. Treatment includes the management of co-morbid conditions such as addictions and eating disorders.
- Acorn unit is a 12 bedded therapeutic environment for women meeting the criteria for borderline personality disorder, dissociative disorder and complex post traumatic stress disorder.
- Spring Lodge is a two bedded specialist step down unit for women meeting the criteria for borderline personality disorder, dissociative disorder and complex post traumatic stress disorder with a focus on occupational engagement.

We have reported on all six units in this report.

The Retreat York has been previously inspected on six occasions. This is the second inspection of the provider as part of our ongoing comprehensive mental health inspection programme.

The most recent inspection was a focused inspection by Adult Social Care of The Cottage and East Villa on 7 June 2016. The inspection team found several areas of concern including: admission of people to the service without 'best interest' decisions, use of restraint techniques for prolonged periods of time, seclusion behind locked bedroom doors, inappropriate use of hand held restraint for the purposes of providing personal care and people only having access to the local community with two-to-one support.

There was an inspection on 27 October 2015 of wards for older people with mental health problems, specialist eating disorders services and the personality disorder therapeutic community that resulted in a requirement notice. In October 2015, we found that the provider had not ensured the proper and safe management of medicines by ensuring they were stored at a safe temperature, disposing of unwanted medicines safely and ensuring that patients who were prescribed as and when required medicines had a clear record of the reasons for this. We found that patients at risk of falls did not have comprehensive plans in place to mitigate this risk including wearing safe footwear. We also recommended that the provider should ensure that activities were provided on the units for older people that met the needs of people with dementia; that the provider should ensure that staff were well informed about

Summary of this inspection

internal whistle-blowing processes; and that the provider should ensure that on the units for older people they should always have a record of the care co-ordinator to assist with discharge planning.

There was a focused inspection of the George Jepson unit on 10 May 2015. The inspection followed an anonymous whistle-blowing concern and safeguarding investigation. The inspection identified staffing shortages and was reported in the 27 October 2015 inspection report.

There have also been three Mental Health Act monitoring visits in the past 18 months. The latest visit took place on Naomi eating disorder unit on 19 September 2016. The Mental Health Act reviewer found that the unit did not automatically refer patients lacking capacity to the advocacy service. During our inspection no patients lacked capacity. There was a blanket restriction on the use of the activities of daily living kitchen which was used by patients to practice skills relating to meal preparation and cooking; This was still the case during our inspection.

The Mental Health Act visit to Katherine Allen older peoples unit was on 26 October 2016. The Mental Health Act visit found concerns with Section 17 leave recording, reflective surfaces on windows and doors that cause confusion to patients with dementia and the lack of a notice to inform informal patients how to leave the unit; these had been resolved by our inspection.

The Mental Health Act visit to the George Jepson older people unit was on 27 October 2015. They did not see evidence of a range of therapeutic activities on the unit during the visit. The corridor leading on to the unit was used at times as a place for patients to eat meals. There was little evidence that discharge planning was taking place. This was still the case during our inspection.

The Retreat York has been registered with the Care Quality Commission (CQC) since October 2010 to provide the following regulated activities:

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

The hospital had a registered manager and a controlled drug accountable officer at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. A controlled drugs accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

During our inspection, 19 patients were detained under the Mental Health Act and 30 informal patients who were able to leave the units if they wished. The following numbers of patients were on each unit:

Wards for older people with mental health problems

- George Jepson unit - 13
- Katherine Allen unit - 11

Specialist eating disorders services

- The Naomi unit - 12

Specialist personality disorder wards

- The Kemp unit - 6
- Acorn unit - 6
- Spring Lodge - 1

Our inspection team

Team leader: Clare Stewart, Inspector, Care Quality Commission.

The team that inspected the service comprised five CQC inspectors, one head of hospital inspections, one inspection manager, one pharmacy inspector, one Mental Health Act reviewer and a range of specialist advisors: one psychologist, one older adult consultant psychiatrist, one board level director, one registered nurse with experience in older adult care, one registered nurse with experience in eating disorders, one registered nurse with experience in personality disorders and one older adult expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

Summary of this inspection

Why we carried out this inspection

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

At the last inspection in October 2015, we rated wards for older people with mental health problems as 'good' overall. We inspected but did not rate specialist eating disorders services as it was a specialist service.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked the local authority, commissioners and Healthwatch for information and sought feedback from staff the week prior to the inspection via telephone interviews.

During the inspection visit, the inspection team:

- visited all six units at the hospital, looked at the quality of the unit environment and observed how staff were caring for patients;
- spoke with 17 patients who were using the service;
- collected feedback from 12 patients using comment cards;
- observed three mealtimes;
- spoke with the registered manager and managers for each of the units;
- spoke with 44 other staff members; including doctors, nurses, occupational therapists, psychologists, social workers, activity coordinators, physiotherapists, dieticians, business support staff, directors and the chaplain for the service;
- spoke with two external consultants working for The Retreat York in organisation development and information technology roles;
- received feedback about the service from the local authority;
- received feedback about the service from 12 care co-ordinators or commissioners;
- spoke with two independent advocates;
- spoke with five carers and family members;
- spoke with two board members;
- attended and observed four hand-over meetings and three multidisciplinary meetings;
- looked at 29 care and treatment records of patients:
- observed one supervision session;
- conducted two short observational framework for inspections (SOFI observations) and observed two activity sessions;
- carried out a specific check of the medication management on all units; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

The older adults patient group had difficulty communicating, however we spoke with five patients who told us that they were happy, that staff were polite when they spoke to them, and they helped them with what they needed. Patients also said that they felt at home and that planned activities and outings were not cancelled due to staff shortages.

Carers for patients on older adults units told us that staff provided great care and were kind and considerate; they felt that their relative was safe on the units. Carers told us that they felt involved in their relative's care and that they knew how to make complaints if required.

We spoke with six patients on the eating disorder unit. They told us they felt safe on the unit but felt that there was not always enough staff available. They described staff as amazing and told us they were valued and supported by them. Patients described the food as excellent.

We spoke with seven patients from personality disorder units during the inspection. Patients told us that staff saw them as people and not as a condition. Patients on Kemp unit explained their discomfort with agency staff and unease with male agency staff members on night shift. Patients told us units were clean and they were listened to.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- All units had issues relating to the management of medication. This included; staff not recording the reasons for missed doses of medication, medication not being dated when it was opened and staff not completing body maps for transdermal patches. Medication care plans were not always thorough and updated, and staff did not correctly record the administration of covert medication. For 'when required' medicines symptoms were not always indicated to guide staff when to administer and staff administration signatures did not always correspond with the prescribed medicines instructions.
- There was one electrocardiograph machine in the whole hospital on Naomi unit and staff sometimes took this off site to another unit 30 minutes away so it was not always available for the monitoring of patient's physical health.
- Units did not staff to establishment levels set by the provider. Activities were cancelled on Naomi unit and Kemp unit and patients told us that staff could not always respond to their requests.
- Risk assessments were not always completed in eight hours of admission as specified in the provider's policy. On older people's units, we found that three out of eleven risk assessments had not been updated on a monthly basis or following an incident or change. They did not always record the action they should take to mitigate and reduce risk when patients refused physical healthcare checks. On personality disorder units we saw two risk assessments had been completed 12 and 18 days after admission which was not in line with the provider's policy.
- Older people's units did not provide information to patients who were staying informally on how they could leave the unit.
- There were some individual training courses such as fire safety, record keeping, professional boundaries and the prevention and management of aggression and violence that had not met the target on units.
- The George Jepson unit was in need of refurbishment.

However;

- On all units, staff had kept their knowledge and skills up to date by meeting the provider's aggregated mandatory training target.

Summary of this inspection

- Clinic rooms and equipment were clean, safe and in date; with the exception of the availability of the electrocardiogram machine, other emergency equipment was available.
- The provider had safeguarding policies and procedures in place and staff knew how to use them and report incidents.
- All patients on older people's units had a falls risk assessment and recovery care plan in place.
- Staff on all services used restraint as a last resort, and de-escalation techniques were clearly documented in individual care and treatment plans.
- Where agency and bank staff were used, the units prioritised the use of familiar staff on the units. Kemp unit offered temporary contracts to qualified nursing staff and support workers.
- In addition to corporate induction, all units had a local induction. However, on Kemp unit, not all agency, bank or staff from other units covering shifts, received a local induction.
- Safeguarding was embedded across the service. There were good links with the local authority. Care and treatment records reflected safeguarding concerns and staff knew and acted in line with the provider policy.
- Staff knew how to report incidents and were able to tell us the process. Incident reporting forms incorporated a duty of candour section and staff were aware of the provider's policy and their responsibilities within this requirement. However, staff were unclear how they received feedback from investigations from the senior leadership team on Naomi unit.

Are services effective?

Requires improvement

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

- There were restrictive practices in place. All units, except Naomi, had locked doors to access the kitchen. Restrictions were not individually risk assessed resulting in restricted access for all patients. On Kemp unit, all patients had to have a staff member unlock the snug and sensory rooms.
- Appraisal rates for the provider were low; 63% across all units including qualified staff and management staff. Management appraisal figures were 33% and the provider told us that senior directors were not appraised. Kemp unit figures (11%) were evaluated separately because staff were still in their probationary period and the unit had opened in May 2016. The provider was aware of the rates and was working towards all unit staff having completed appraisals by the end of January 2017.

Summary of this inspection

- Supervision rates were low on the units and did not adhere to the provider's own policy. Staff on all units did not receive regular individual supervision, although they did have weekly group supervision.
- There was not sufficient administrative support to ensure to ensure that all patient information was readily available to staff when they needed it.
- We did not find staff on Naomi unit had access to external training.

However;

- Staff on all units had received training in the Mental Health Act and documentation was in good order.
- Staff had received training in the Mental Capacity Act and staff undertook capacity assessments in an appropriate manner with best interests' decisions being made in conjunction with patients' advocates and their families.
- Staff worked as a multidisciplinary team involving all professional appropriate to support a patient. Patients' physical health care was also apparent.
- Most units had access to specialist training both internally and externally. Older people's services were in the process of completing an analysis of dementia training needs.

Are services caring?

Good

We rated caring as **good** because:

- We witnessed care that was compassionate and staff attitudes were responsive and respectful when speaking with patients.
- Patients told us that staff were respectful and polite.
- Carers told us that they felt their relative was safe and well cared for.
- Patients and carers were involved in their care and the running of the service.
- Staff knew patients well and had taken time to understand their needs, wishes and preferences.
- Advocacy was actively and visibly involved on all units.

However;

- Patients on Kemp unit told us that they were uncomfortable with agency staff use at night; the service was aware of this and had collaboratively worked with patients to improve how agency staff were used.

Are services responsive?

Requires improvement

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

Summary of this inspection

- Patients on older people's units had significantly long lengths of stay. On George Jepson unit the average was 6.8 years and on the Katherine Allen unit it was 6.1 years; for some patients, the placement was not appropriate.
- Although we found the complaints process to be clearly defined with distinct timescales, the recording of verbal complaints on the units was less clear. We found limited evidence that people were supported to complain. We saw a complaints leaflet that said patient care would not be affected as a result of a complaint however we saw no further evidence in the complaints records reminding patients or families of this.
- The dining areas were small on older people's units and the eating disorder unit. There was not sufficient space for patients and the staff supporting mealtimes on the units.
- On George Jepson unit we witnessed patients sleeping on beanbags and chairs on corridors and saw recordings, which indicated they had been asleep for several hours. Staff felt restricted by zonal observations they were taking part in. However, one to one activities were taking place with some patients and some activities happened off the unit.

However;

- A full range of rooms and equipment was available to support treatment and care.
- There was a full range of therapeutic activities available on all units; although, on the George Jepson unit we saw limited meaningful engagement when patients were not in scheduled activities.
- There was access to a range of spiritual and faith support facilitated by the chaplain. They included different patients' faiths into services and interactions.
- Catering incorporated patients' dietary needs and preferences, catering staff worked with dieticians and patients to promote interest in food and encourage changes to menus.

Are services well-led?

Good

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

- Staff on units felt supported by their immediate line managers and spoke positively about them. Staff supported each other and offered help to ensure the best outcome for patients.
- Staff worked within the values of the provider, and we saw evidence of care provided in line with the organisational values.
- All staff spoken with knew who the senior managers were within the organisation and confirmed they were visible on the units.

Summary of this inspection

- Staff had good knowledge of safeguarding procedures, reporting procedures and how to identify abuse. Staff had been trained in and evidenced knowledge of the Mental Health Act and Mental Capacity Act.
- Units were taking part in clinical research, accreditation and peer review schemes.

However;

- Staff told us that outwith their unit they did not feel comfortable in raising concerns to senior management due to the blame culture of the organisation. However, they also told us that they felt hopeful that the newly appointed chief executive was addressing the issues.
- Staff told us of informal feedback on learning from incidents. However, staff were less aware of formal mechanisms such as debriefs and email updates from the leadership team.
- We saw that there were issues with administration of care and treatment records and maintenance not being completed in a timely fashion due to a restructure of non-clinical support staff.

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.

There had been three Mental Health Act review visits in the past 18 months.

The provider had employed a Mental Health Act lead who oversaw all matters relating to the Mental Health Act. The Mental Health Act administrator also provided training and advice for unit staff. All units exceeded the Retreat York's compliance target of 80%.

Patients detained under the Mental Health Act were made aware of their rights on a regular basis. Patients were supported to access local independent mental health advocates and met with them on a fortnightly basis, although this was not automatic for patients who lacked capacity on Naomi unit. Patients were able to appeal against their section at tribunal and take section 17 leave.

We reviewed the files of 13 patients detained under the Act and found documentation to be in good order.

The Mental Health Act administrator undertook regular audits and updated staff on changes in practice monitoring adherence to the Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider was adhering to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The provider had a comprehensive policy for both.

The Retreat York had made eight Deprivation of Liberty Safeguard (DoLS) applications between 01 March 2016 and 31 August 2016. We reviewed these and found that staff applied for them in a timely manner in conjunction with the supervisory body. Where patients had a deprivation of liberty and where the local authority could not meet the assessment dates, the provider had safeguards in place to protect the patient's human rights.

Where necessary, staff had undertaken capacity assessments with patients who were unable to make decisions in relation to their care and treatment. Best interest discussions were taking place on a regular basis in multidisciplinary meetings with the support of a patients' family and advocate or independent mental capacity advocate.

Completion of training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards was mandatory for all staff and compliance levels of 91% were above the provider's target of 80%. Staff demonstrated a good understanding of the Mental Capacity Act and its principles. Staff were able to tell us about the principles of the Act and we saw evidence in care planning of how the Act influenced direct patient care.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Specialist eating disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Tier 3 personality disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

The Katherine Allen and George Jepson units had blind spots (areas where staff could not see patients at all times). There was an increased risk of harm to patients because both units contained ligature points. A ligature point is something, which people can use to tie something to in order to strangle themselves. Unit managers told us that the risk was mitigated because all staff were aware of the risks on the units and these were regularly audited and entered on the risk register. In addition to this, we observed that staff monitored patients throughout the day and night by the use of zonal observations. This meant that staff had an awareness of a patient's whereabouts at all times in order to keep them safe.

The provider had designated the Katherine Allen unit for female patients only and the George Jepson unit for male patients only. This followed Department of Health same sex accommodation guidance.

Both units had fully equipped clinic rooms available to allow staff to examine and treat patients. Both clinic rooms had grab bags and resuscitation equipment available and we saw that staff checked and audited these regularly. There was a defibrillator available, and both rooms were clean and tidy. However, on both units we found three open tubes of hydrocortisone cream that staff had not dated when they opened them. This meant that staff could not be sure that the cream was fit for use in line with the manufacturer's instructions. The whole hospital, including the site 30 minutes away shared one electro-cardiograph machine, this meant that it was not easily accessible to monitor patient's physical health; this was important for patients with heart problems or those patients treated with rapid tranquilisation.

The older people's units did not have seclusion rooms and staff told us that patients were not secluded. Staff said that if patients became agitated, they would encourage them to a quieter area on the unit such as their bedroom or a low stimulus room and remain with them, using techniques such as distraction until the patient became calm. The unit managers told us that staff always left doors open to allow patients to leave if they wished to. Because the unit did not have a seclusion room, should a patient require seclusion when no other techniques could support them, the patient would be transferred to another service that contained such a facility, or a unit such as psychiatric intensive care. There had been no occasions of this occurring on any units. The service provided us with data, which stated that there had been no episodes of seclusion on older people's units in the last three months.

Both units were clean and tidy and we saw evidence of domestic staff working on both units to maintain the environment. However, the building had limitations due to its historical nature and this meant that neither unit had been designed for specific use for patients with dementia. Staff had made changes to the environment such as using soft toys and memorabilia to provide a more comforting environment for patients. The George Jepson unit did have tired decoration, and the unit manager told us that The Retreat York were making plans for re-decoration of this unit. However, we spoke with patients, carers and staff who

told us that although the environment was dated, the nature of the building and its extensive grounds provided patients with a relaxing atmosphere that was homely and aided their recovery.

Both units had activity rooms, which patients could access, and both had access to outside space. George Jepson unit was located on the ground floor so had direct access into a garden. The Katherine Allen unit was located on the first floor so did not have direct access to outside space. Access to outside was locked on both units and could only be accessed by patients who were escorted. Staff told us that this was because of high falls risks for the patient group, this had not been individually risk assessed for each patient.

Both units had specific dining areas for patients. However, these were small and did not meet the needs of the patient group. For example, both dining areas could only seat seven or eight patients, and did not provide enough space for patients who wished to eat alone. This meant that patients were eating and being supported to eat in the unit corridors. Staff told us that this was patient choice, however not all patients could be seated in the dining area with staff supporting mealtimes at any one time.

Staff wore alarms that they could use should they feel at risk from a patient or need assistance to support a patient. Patient bedrooms had nurse call alarms on the walls which patients were able to use as needed.

Safe staffing

The provider submitted nursing establishment whole time equivalents on George Jepson unit between 1 June 2016 and 30 August 2016 as:

- Qualified nurse whole time equivalents: 9
- Support worker whole time equivalents: 24
- Number of vacancies – qualified nurse whole time equivalents: 0
- Number of vacancies – support worker whole time equivalents: 9
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 40
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 182
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 29

The unit manager also explained that two of the qualified nursing posts on this unit are occupational therapists who the provider employed as part of the establishment shift levels to improve levels of engagement and activity on the unit following feedback from the last inspection. In August 2016 the unit had four pending new starters. When shifts were not filled by bank or agency staff (where there was sickness, absence or vacancies) the unit worked under establishment levels.

The Retreat York submitted nursing establishment whole time equivalents on Katherine Allen unit between 1 June 2016 and 30 August 2016 as:

- Qualified nurse whole time equivalents: 9
- Support worker whole time equivalents: 18
- Number of vacancies – qualified nurse whole time equivalents: 2
- Number of vacancies – support worker whole time equivalents: 0
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 48
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 32
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 4

In August 2016 when the data was submitted, the unit had two pending new starters plus two long term qualified nurse agency staff.

Both units used bank and agency staff to cover vacancies, leave and sickness. However, the number of agency staff used on George Jepson unit was higher. This was because of the higher level of vacant nursing posts on this unit. During the three-month period the George Jepson unit ran below its agreed staffing establishment on 29 shifts, this put patients at risk because staffing numbers are designed to meet patient need, which cannot always be met when the staff numbers are not reached.

However, the provider told us that when agency staff were used they were often on long term contracts, which meant that the consistency for patients was ensured. Agency staff received a local induction to the units that incorporated an outline of the facilities, security arrangement, daily routine, zonal observations and points on patient safety. Staff had to sign that they had read and understood the information in the pack.

Requires improvement

Wards for older people with mental health problems

Unit managers told us that during the managers' morning meetings staffing numbers were shared and units which are below staffing numbers are highlighted in this meeting and staff from other units may be moved around to support patient need.

The staffing establishments were set across both units as two nurses (or one nurse and one occupational therapist on George Jepson unit) and five support workers on each day shift which was 7am to 8pm, there was the same staffing establishment on the night shift which was 7:30pm to 7:30am, this allowed for time for staff to handover information to the new shift each morning and evening. Of the five support workers at night, two of these worked a 'twilight' shift and worked until 11pm to support the busiest time on the units.

Unit managers told us that in the last six weeks they have had more autonomy to increase their staffing levels on the unit. Managers call the site co-ordinator on shift each day or night to request additional staff internally. Agency or bank staff were then requested if Retreat York staff could not fill the shift. Managers told us that they felt able to call for more staff if patients were unsettled or needed additional support.

In addition to nursing and support staff, both units had access to the multidisciplinary team, which consisted of occupational therapists, psychologists and psychiatrists.

The provider had an overall staff turnover of 16% or 47 substantive staff in the last twelve months; Of the 26 substantive staff on George Jepson unit, nine (35%) had left in the last 12 months and on the Katherine Allen unit, six staff (21%) of the 29 substantive staff had left in the same period. Staff told us that changes in management structures and systems had been difficult for some staff who had worked for the organisation for a number of years and this was the reason for the high level of staff leavers in the last 12 months.

We spoke with staff and patients who told us that planned activities on the units were never cancelled due to staff shortages on either unit. Staff told us that if units were short staffed, activities would be changed to reduce risks for example by changing an outing to remaining within the hospital grounds for coffee rather than a trip out. One patient we spoke with from the Katherine Allen unit told us that sometimes there was not enough staff, and one staff member from the George Jepson unit told us that it could be difficult to attend training at times due to low staffing numbers.

The unit managers explained that at a recent review, all unit administrative clerks previously allocated per unit had been reassigned to 'pooled' working. Managers and staff told us that because of this, the administrative role for managers and nurses had increased significantly, and they had less time available for direct patient care.

Unit staff told us that there was adequate medical cover day and night, and that a doctor could attend quickly in an emergency. However, there was only one doctor allocated to both units, who also covered another unit 30 minutes away from the location. The doctor did not have junior doctor support and we felt that this was a high caseload for one doctor to manage, particularly on days when the doctor was based 30 minutes away at another location.

Both units followed the mandatory training as set by the provider. Average training compliance was 83% (George Jepson) and 89% (Katherine Allen) which is above the provider target of 80%.

The following courses on George Jepson were below The Retreat York compliance target:

- Immediate Life Support: 77%
- The Importance of Good Clinical Record Keeping: 76%
- Basic Life Saving: 75%
- Child Protection Level 1 Basic Awareness: 75%
- Record Keeping Standards for Hospital Inpatients: 72%
- Introduction to Information Governance: 69%
- Fire Safety: 60%
- Prevention and management of violence and aggression Level 2: 50%
- Professional Boundaries: 47%

Of the courses below target the provider confirmed that prevention and management of violence and aggression Level 2 is currently only assigned to staff as a reasonable adjustment when they are physically unable to do the full prevention and management of violence and aggression course (Level 3). Level 3 prevention and management of violence and aggression was above the provider target at 87%. Professional boundaries was an updated course rolled out at the end of 2015 and training figures were 47%.

Requires improvement

Wards for older people with mental health problems

The following courses on Katherine Allen were below the provider compliance target:

- Introduction to Information Governance: 71%
- Professional Boundaries: 34%
- Prevention and management of violence and aggression Level 2: 0%

We reviewed the figures for the training of bank staff as bank staff were used frequently on these units. Overall training compliance for bank staff was 85%.

The following courses were below the target:

- Face Care Partner - Basic Competency Training: 78%
- Fire Safety: 49%
- The Importance of Good Clinical Record Keeping: 30%
- Record Keeping Standards for Hospital Inpatients: 25%

Across the service, the lowest levels of mandatory training were in fire safety, professional boundaries and record keeping. The provider told us that they were aware of lower compliance in these areas and was sending reminders to staff to complete these courses as well as reviewing staff training in prevention and management of aggression and violence level two.

During the inspection, we did not see an impact on direct patient care with regard to the lower areas of training compliance.

Assessing and managing risk to patients and staff

Both units reported that they had not used seclusion in the last three months and did not have a seclusion facility.

Between the 1 March and 30 August 2016, George Jepson used restraint techniques on 43 occasions with five patients, none of these were episodes of prone restraint (where a patient is restrained face down) and there was no use of rapid tranquilisation. During the same time there were five patients on the Katherine Allen unit restrained on eight occasions, none of these were prone restraint and there was no use of rapid tranquilisation.

Managers told us that the majority of restraint incidents concerned personal care interventions which patients found difficult. However, we saw evidence in care plans and multidisciplinary meetings that the staff used restraint in the least restrictive manner and as the last resort. For example, staff would wait to support with a personal care tasks until the patient had settled and felt more comfortable rather than using restraint as a primary response.

Any restraint used was reported and reviewed and care plans and risk assessments changed to accommodate this in line with the organisation's policy. The units used restraint as a last resort when all other attempts to de-escalate the situation had failed. We saw evidence of this success with one patient who required the support of five staff with personal care when he arrived on the unit, now only needed one staff to support. This was because the staff team had used case formulation to think about the impact of personal care on this patient and how to work with them to reduce distress. We also found evidence of staff working with others outside the unit for support with specific cases such as working with the learning disability service regarding a patient with a learning disability accommodated on the unit. Unit managers told us that staff observed vital physical health signs following any restraint for up to 24 hours dependant on the level of restraint used. Although staff did not use rapid tranquilisation on the units they were aware of the care needed following its use to keep patients safe.

We reviewed six patient care and treatment records on the George Jepson unit and five records on the Katherine Allen unit. We saw that most records had an updated risk assessment and that these were updated on a monthly basis or sooner should an incident occur. Risk assessments contained crisis plans and positive behaviour support plans to support staff and patients should patient needs suddenly increase. However, we saw that although most risk assessments had been recently reviewed, three of the 11 we saw staff had not updated them since September 2016 on the George Jepson unit.

An initial risk assessment using the 'functional assessment of the care environment' risk assessment was completed for all patients within four hours of admission alongside a 24 hour recovery plan for the patient. The service asked referrers to provide an initial risk assessment within the handover to the unit where possible. A more detailed version of the risk assessment was then completed, a 'risk profile'. Staff then updated risk profiles after any incident

and staff nurses reviewed them monthly. Risk was also discussed in multidisciplinary team meetings, formulation meetings and handovers should an incident occur and review of risk be required.

We saw blanket restrictions in place on both units. A blanket restriction is a rule which applies to everybody regardless of their particular needs and circumstances. For example, staff locked the entrance and exit doors to both units and patients could not leave without staff permission or support. Access was restricted to certain areas, which may be high risk to patients such as kitchens, and areas of the unit where patients may fall such as the garden. Staff told us that this was for patient safety and to ensure they could monitor the whereabouts of the patients at all times due to the frailty and vulnerability of the patient group. However, this was not individually risk assessed so applied to all patients.

On George Jepson unit there was one patient who was admitted to the unit informally at the time of our visit. Nine patients were detained under a section of the Mental Health Act, and three patients were accommodated using Deprivation of Liberty Safeguards. On the Katherine Allen unit, two patients were admitted informally, five were accommodated using Deprivation of Liberty Safeguards and four were detained under a section of the Mental Health Act. When patients are admitted informally, they must be able to leave at will. However, organisations must balance this right with their duty of care to a patient who may be a risk to themselves or others and in need of treatment in hospital. The units had not balanced this risk by providing information to patients on the units who were staying informally about how they were able to leave the unit.

Both units used a method of zonal observation, which had been a recent change in policy. This meant that staff were placed in specific zones on each unit to enable them to observe patients in all parts of the units. This reduced risk of falls, ligatures and self-harm. However, we saw that staff were observing patients on George Jepson but this left them feeling restricted in their ability to engage with patients due to their concerns about leaving their zone of observation to engage with a patient. This policy is a recent change and requires time for staff and patients to adjust.

Patients were not searched routinely, and would be asked to share their belongings with staff should a risk be identified.

Staff knew how to make a safeguarding referral and were trained in safeguarding adults and children. The Retreat York had an internal social work team who supported unit managers to manage safeguarding, made referrals to the local authority and to CQC. Between September and November 2016 George Jepson unit made 12 safeguarding referrals and Katherine Allen made three safeguarding referrals. Unit managers told us that these mainly related to patient on patient assault. Each month the unit managers went through the safeguarding referrals with the social work manager and tracked progress and action plans for consistency.

We reviewed medicines management practice on both units. On both units, the medicines were stored securely and access was restricted to authorised staff. George Jepson unit housed the out of hours medicines cupboard for the hospital, and this was appropriately managed with clear documentation for what had been used and by whom. Staff recorded clinic room and fridge temperatures daily and managers had recently reminded staff about the importance of resetting the thermometer as staff had recorded 8.1 degrees centigrade for one week without follow up. Controlled drugs were stored securely. However staff did not record stock checks weekly in line with the medicines code requirements. We found three tubes of cream that staff had opened and not dated. Medicines reconciliation was completed for all new admissions by the pharmacy technician led service. Staff described a good working relationship with the pharmacy and patients were able to speak directly with a pharmacist if required.

Medicines code and rapid tranquilisation policies were reviewed annually by the designated pharmacist. The pharmacy received, actioned and disseminated medicines alerts and recalls, and this was appropriately managed. Medicines incidents were broken down into core areas and were analysed by the pharmacy department. All incidents were reviewed in the clinical governance group as a standard agenda item and a pharmacist attended these meetings. Learning from incidents was shared and we saw how controlled drugs incidents had prompted a training package being developed.

On George Jepson unit staff used codes to document missed doses on medicines charts. However staff did not record reasons for the code or action taken to encourage administration or to inform the prescriber of the missed

dose. The electronic medicines record in the patients' daily notes recorded 'not undertaken' or 'undertaken' for administration but this did not always correspond to the codes documented on the medication chart.

Care plans did not always provide detailed medicines information or cover all aspects of care. Staff did not always update them when changes had occurred. For example, one patient who used inhalers had no respiratory care plan and this was not referred to in their medicines care plan. Another patient's care plan referred to 'when required' medicines that were no longer prescribed, and no entry had been made by staff to show when this change had occurred.

Staff administered medicines covertly to some patients (without patient's knowledge) into food and drinks. Staff did not always document best interest discussions and decisions in patient records. For example, one patient had a covert medication care plan but this was not noted in the risk assessment and the care plan did not state which medication this plan was specific to. The notes stated that this medication had been authorised by a T3 certificate but as this was a medication for a physical health issue this was incorrect use of the certificate. T3 certificates authorise the use of mental health medication. A second patient had covert medication discussed in the multidisciplinary meeting in November 2016, and agreement made that medication could be mixed into a drink. However by the time of our inspection this had not been noted on the patients' care plan. This meant that staff that did not attend or read meeting minutes would be unaware of this change and could lead to medicines errors.

We also saw that one patient was prescribed a pain medicine in the form of a transdermal patch. However, body maps were not consistently used to identify the locations where patches had been placed. This increases the risk of skin sensitisation and irritation.

To reduce the risk of errors on George Jepson unit, all medication charts were checked at each handover meeting.

On the Katherine Allen unit we did not find any issues with medications management. However, we found that three patients were on covert medications that had been reviewed at multidisciplinary meetings every four weeks. However, these were not specifically documented on care plans and risk assessments.

We found on both units that when medication was given covertly, staff did not record on the medication charts how the medication was given. For example a patient may except medication orally one day but need covert medication the following day. This meant that staff could not track when medication was given covertly and how this was given. There was also limited pharmacy input into multidisciplinary meetings and therefore advice and expertise could not be shared.

Due to the frailty of the patient group on both units, staff were aware of other issues aside from patients mental health needs. Each patient had a falls risk assessment in place and a falls recovery plan. Patients with complex needs or a high falls risk were referred to the onsite physiotherapist. Staff also monitored other risk areas such as skin integrity by using a waterlow scoring tool each month and a nutritional screening tool. Staff referred to tissue viability nurses and speech and language therapists outside the organisation if required.

Families visited their relatives on the units. However visits from children on units were discouraged due to the unpredictable behaviour of some patients, although the service had children's visiting area available in the shared area in the main building that could be used should relatives bring children to visit patients.

Track record on safety

Between January and December 2016 the CQC were notified of four serious incidents on the George Jepson unit and two serious incidents on the Katherine Allen unit. Of these six incidents two were whistleblowing reports from staff directly to CQC and the other four were reported internally. Of these incidents two were accusations of staff causing alleged harm to a patient, one referred to food, one to activities, one to an unexplained bruise on a patient and one related to seclusion.

The incidents were investigated and reported to the local authority at the time and a concerns meeting was held to discuss these issues and an ongoing action plan, which CQC attended at the time.

We asked staff if they felt confident in raising issues and concerns about care and practice with the senior management team. Staff told us that they felt comfortable and supported at a local level but would not feel confident talking the senior leadership team because they worried that this would cause them difficulty in their role. However,

staff told us that since the new chief executive arrived the open door policy had been renewed and they think that they would approach the chief executive for advice and support if needed.

Reporting incidents and learning from when things go wrong

All staff knew how to report incidents and were able to use the incident reporting system. Unit managers took all incident reports to the morning managers meeting for review and discussion, which allowed them to obtain advice and support from other managers. Managers also reviewed each incident and fed this back to staff as required. This also ensured consistency in the approach and allowed them to track themes and trends. For example, by tracking incidents, older people's units became aware of an increasing level of patient falls on the units and an action plan was in place to address this. We saw that a safeguarding form was attached to the incident report form, which reminded staff to report incidents that were also a safeguarding concern.

The provider told us that George Jepson was the highest reporter of incidents with 597 incidents reported between June 2015 and June 2016.

The risk manager at The Retreat York checked incoming incidents each working day and could return incident forms to reporters when they lacked detail or were wrongly categorised. Under the provider's risk management policy, the unit managers or deputy completed their review of an incident within 72 hours of a report being sent. The decision to initiate further investigation rests between the risk manager, the unit manager and senior management.

Following any significant restraint, a review was completed and staff told us that de-briefs were offered following a serious incident. Managers also attend a monthly shared learning meeting with other senior team members and told us that they feed this back to other staff in team meetings and in supervision sessions.

We saw evidence that lessons had been learned from incidents, for example practices at lunchtimes had changed when the provider received a concern about cold food being served on the George Jepson unit and staff were offered support in ensuring equipment was used correctly. The change to zonal observations was a response from the provider to an increase in falls on older people's units and an increase in self-harm incidents on other units across the hospital.

With some explanation of the term, staff had an awareness of the duty of candour and how to use this to ensure that service was open and honest with patients and their families when they had made mistakes. The organisation had a duty of candour policy that detailed the organisational approach to duty of candour. We reviewed this policy during our inspection. Duty of candour was discussed at unit managers meetings and if incidents warranted investigation, the chief executive officer and registered manager were informed. Unit managers provided explanations verbally and in writing. A duty of candour log was kept on the shared drive and was reported to the governance committee.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed the care and treatment records of 11 patients, which were held on the provider's electronic system. The files were secured by a password and only accessible by staff. Agency and bank staff had user accounts and were able to update the system. We saw that the majority of patients had comprehensive care plans in place, which had been updated in the last month prior to our inspection. However, we saw that five patient care plans on George Jepson unit had not been updated in the last three months prior to November 2016.

Patient care plans were personalised and holistic. We saw that they contained information about a patient's whole life including their likes, dislikes and any preferences they had for their care. Care plans contained a patient's history such as what they used to do for employment and this linked into other areas such as activities for that patient. Care plan contained details about how staff should support a patient in a crisis such as by providing reassurance and one to one time. We also saw that they contained areas of strength and needs for each patient and goals for recovery. Care

plans contained positive behaviour support plans, which indicated to staff an initial, secondary and final response to behaviours which challenged to ensure the least restrictive option was always the first intervention tried by staff.

All care records reviewed evidenced that patients had ongoing physical health checks. Physical health screening such as weight, blood pressure and temperature was completed on a monthly basis and nutritional screening tools and waterlow scores also completed at the same time. If a patient had an increased need, this was completed more regularly. One patient had daily physical health checks due to medicines they were taking. However, we saw evidence that patients often refused these interventions and interventions such as urine tests or taking blood. Therefore the outcome of these checks could not be recorded. Staff told us that when this happened, staff would visibly monitor patients' wellbeing and if they appeared unwell this would be discussed at multidisciplinary meetings to plan an intervention. This left patients vulnerable to developing underlying health conditions which would not be picked up in ongoing physical health checks. The records of one patient told us that their health had only been checked once between 1 December 2015 and 28 November 2016 due to the patient refusing these checks. There was not a care plan in place which addressed and mitigated the risk. The units had a local GP visit twice per week and also had access to district nurses if this was required. Neither had access to the electronic system and a paper record was kept in a separate file. Staff told us that scanning the notes of other professionals onto the system was historically completed by the unit clerks. However, since a restructure of the administration staffing, it had now become the duty of the night staff. We were told and observed that daily blood tests could sit for several days before bring recorded on the system. The consultant psychiatrist on the unit would telephone the local hospital for the results when blood tests had been taken from patients to reduce the risk, but these results could not be seen by all staff due to the delay in scanning these onto the care record.

Best practice in treatment and care

The units used a variety of methods to embed best practice. The provider's overarching medicines framework linked to the National Institute for Health and Care Excellence guidance. The electronic system supported staff by pulling this guidance into individual care plans such as; Service user experience in adult mental health (CG136) and Falls in older people, assessing risk and prevention (CG161). We also saw medicines management guidance linked to care and treatment records. Both units used rating tools to identify patient need such as a nutrition screening tool, the waterlow scale to monitor skin and tissue viability, and early warning scores. All patients had a falls assessment and falls recovery plan in place and were referred to other professionals should any of the screening tools identify an additional need for that patient.

The two units had access to the support of a psychologist and assistant psychologist. They attend multidisciplinary team meetings and support with formulation and offered psychological interventions. The psychology team also supported the units with behaviour management plans and identifying and managing triggers to behaviour.

Patients had access to food, drinks and snacks throughout the day and we saw evidence when observing meal times that staff offered patients a choice of meals. Staff locked kitchen areas due to risks of burns or scalds. However, each dining area had an open hatch into the kitchen where patients could talk to staff and make choices about what they would like to eat. We observed a mealtime on each unit. On both units the mealtime was not a therapeutic experience that promoted recovery for patients. There were not enough seats in the dining area for all patients with support from staff, meaning that some patients were eating meals off over bed tables on the corridors. Staff told us that this was a preference for some patients who did not like to sit in the dining room with others. Staff were observing patients both within and outside the dining area and supported some patients to eat in their rooms on the Katherine Allen Unit. This meant that risks were monitored and the staff where always aware of a patients food and fluid intake. Patients were supported to eat and drink and specialist equipment was available to support patients. Staff were caring when supporting patients and gave them time to digest food between mouthfuls.

Unit managers told us that staff completed audits on each unit including Mental Health Act audits monthly, medication card audits daily, case file audits each month, a weekly audit of the electronic system and daily monitoring of clinic room and fridge temperatures.

The provider did not carry out any national audits such as the national audit for schizophrenia or psychological therapies as it did not have minimum number of sample patients to enable them to participate.

Skilled staff to deliver care

Both units worked with a multidisciplinary team and had links with other professionals such as general practitioners who visited twice weekly and district nurses who visited when required. The units could also refer to outside agencies for speech and language therapy.

Staff were experienced and qualified to perform their role, they had completed mandatory training which was specific to their role. Mandatory training was above 75% on all but three courses on Katherine Allen unit and five courses on George Jepson unit.

The provider had a local and organisational induction programme for new starters including bank staff. On George Jepson unit, two support workers had developed a unit level induction and they had time away from usual duties to support new staff members. The programme for all staff included e-learning and face to face training. Support worker training also covered aspects of the support worker care certificate. There was a unit checklist for bank and agency staff that was completed in conjunction with the nurse in charge. Agency staff received a local induction to the units that incorporated an outline of the facilities, security arrangement, daily routine, zonal observations and points on patient safety. Staff had to sign that they had read and understood the information in the pack.

The Retreat York had a supervision policy that stated qualified staff should have nine supervision sessions per year with their supervisor. Support workers were not offered any formal supervision by the organisation but could access group supervision if required which ran on a fortnightly basis. Group supervision for qualified staff ran on a weekly basis. On the George Jepson unit, 10 qualified staff should receive supervision nine times per year on average, the data provided evidenced that most staff had received this six times in the last 12 months although two nurses on this unit had only received supervision once or twice in that period.

On the Katherine Allen unit 10 qualified staff had not received supervision as per the policy and the unit manager had recorded that only one supervision had taken place in the past 12 months. Two staff members had received six supervision sessions, the remaining staff had completed three or four sessions in this period.

On the George Jepson unit, only 58% of non-medical staff had an appraisal and 66% of staff on the Katherine Allen unit. This meant that staff were not receiving regular supervision and appraisal. When this is not in place, staff are unable to reflect on good or poor practice, set goals, and discuss training and development needs. This also reduces opportunity for managers to share lessons learned and good practice with staff.

Unit managers told us that there was about to be a roll out of dementia training, including dementia care mapping and dementia awareness. However, this had not started and was not part of mandatory training for staff working on the older people's units. The service had a training manager who recorded mandatory training for each unit. Additional training was delivered by staff on the unit. However, recording of additional training was not centralised. We asked the service for details of additional training for all units including older people's services. They told us that staff accessed wound care in mental health, phlebotomy and continence care training.

We saw evidence that staff performance was monitored at unit level and that concerning performance or incidents were investigated and managed by the senior leadership team. One staff member had been suspended in the last twelve months and two staff were on long term leave on medical grounds.

Multidisciplinary and inter-agency team work

Both units worked with a multidisciplinary team, which included nurses, support workers, psychiatrists, psychologists, occupational therapists, advocates, physiotherapists, pharmacists, activity workers, volunteers and social workers. The units also had links with other professionals such as general practitioners who visited twice weekly, district nurses who visited when required and could refer to outside agencies for speech and language therapy.

The teams met on a weekly basis on both units, meaning that each patient's care was discussed every three weeks on average. However, meetings could be brought forward as required. Patients and their carers were invited to these meetings and we saw that detailed minutes were taken of

each meeting. In addition to these meetings, each patient had a care programme approach meeting every six months. We observed a multidisciplinary meeting and found that this was detailed and staff presented detailed knowledge of the patient. The meeting discussed capacity, best interest decision making and family involvement. In addition to this the meeting made clear action points for named staff members to complete to ensure actions were followed up.

The teams on each unit also met twice daily for a unit level handover meeting. We observed two of these meetings during the inspection. The handovers included nurses, occupational therapists and support workers and unit managers attended where possible to quality check the process. The handovers we observed were concise and discussed each patient on the unit, their presentation and behaviour, observation levels, detention, medication changes, activities, and staff roles.

The Retreat York's social work team had developed a sound working relationship with the local authority. The social work team had met with the local authority to discuss the ongoing concerns regarding George Jepson unit when there had been several safeguarding alerts on the unit. Staff told us that they invited funders who commissioned placements to safeguarding meetings and CPA meetings, and one patient was having a care and treatment review in the near future. However, not all patients had an allocated social worker from the mental health teams on these units as placements were often long and discharge had not yet been discussed.

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

The provider employed a Mental Health Act advisor; staff knew who this was and how to make contact for support when required. The Mental Health Act advisor had comprehensive monthly audits in place for use of urgent treatment, holding powers and temporary holds on informal patients. The provider's audit manager conducted additional audits on information given to detained patients, leave of absence from hospital and consent to treatment.

Both units had admitted patients who were detained under the Mental Health Act. Training in the Act was mandatory for all staff and the organisation had reached above 90% in compliance. The revised Code of Practice had been incorporated into this training.

We reviewed the care and treatment records of seven patients across both units who were detained under the Act. We found that paperwork was in good order and audited by staff on a regular basis. Staff explained patients' rights under the Act to them on a regular basis, and most patients were supported by an independent mental health advocate. Patients' families were involved in their care and their contact details clearly documented on care records. Where patients lacked capacity to consent to treatment the hospital made referrals for second opinion appointed doctors. T3 forms were filed within patient records. (Form T3 is a Certificate of second opinion. It is a form completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.) For one patient the use of covert medication was noted to be authorised by a T3 certificate of treatment, this was incorrect use of the certificate.

Both units cared for patients who were admitted informally, we saw that practice was good in relation to assessing capacity of these patients to remain an informal patient. However, neither unit had clear information accessible to patients that advised informal patients about how they were able to leave the unit. Doors to both units were locked at all times and no patients had the key code for entry or exit.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act was mandatory for staff and compliance rate was above 90%. Staff were able to tell us about the principles of the Act and care records evidenced that all staff used the Act to support decision making on a day to day basis with patients. It was clear that capacity to consent to treatment, personal care and medication was regularly reviewed at multidisciplinary meetings and the organisation used the two stage assessment of capacity recommended in the Code of Practice.

Requires improvement

Wards for older people with mental health problems

There were patients on both units who were being cared for using the Deprivation of Liberty Safeguards. Documentation for these patients was in order and we saw evidence that staff made applications for new assessments in a timely manner to the local authority.

Patients who lacked capacity and required support were referred to independent mental capacity advocates.

However, we saw evidence that patients were being treated with covert medication on both units. This was discussed in multidisciplinary meetings with all staff and with family members. However, medication cards did not clearly document this. We did not see evidence that staff were recording and assessing capacity on each occasion that covert medication was used.

Adherence to the Act and Code of Practice was audited by The Retreat York's audit lead. They reviewed deprivation of liberty applications, capacity assessments and audited unit managers to confirm if patients had been informed of their rights.

Staff worked within the Act's definition of restraint by ensuring that use of restraint techniques was a last resort, for the shortest time possible and only after all other steps to manage a crisis had been used. This was evidenced in the positive behaviour support plans patients had in place.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

We undertook observations of staff interactions on both units using a Short Observation Framework for Inspection and by talking to patients and carers and escorting some patients on an activity in the grounds of the provider.

We found that staff were kind and caring. Staff approached patients in a quiet and calming manner and at a level appropriate to their understanding. We saw staff react quickly to patients requiring support and felt that all staff spoke to patients in a dignified manner. Staff knew the patients they were working with and were able to offer interventions based on their personal preferences, for example we saw a staff member offer a special salad to a patient which they had saved for the patient knowing they liked it.

All of the five patients we spoke with told us that staff were polite when they spoke to them, and helped them with what they needed. Patients also said that they felt at home and happy.

Carers told us that staff provided great care and were kind and considerate and that they felt that their relative was safe on the unit.

We received two comments cards in relation to care and treatment on George Jepson unit; none were received for the Katherine Allen unit. One carer told us that their family member's clothes had gone missing and they had seen them on other patients and another praised staff and told us their relative had a good diet.

The involvement of people in the care they receive

The Retreat York work to values which included a strong ethos that all patients are treated as equals. Due to this, the units used a variety of methods to ensure patients were able to input into their care and treatment. The majority of patients on the units were unable to communicate verbally with clarity, therefore, the units needed to find more creative ways to involve them in care.

For example, a new model of care was being developed for the units for older people. The provider had involved patients in this and some were able to give feedback to staff on how the unit should be managed. The units have enabled patients to be involved in the recruitment process by holding a coffee morning when patients have been unable to attend formal interviews.

In order to ensure patient care is personalised the units use formulation meetings and support from family members to identify patient preferences. For example, a patient has lunch from a sandwich box as he eats better because this is how he had lunch at work before he became unwell. We saw evidence that care plans contained detailed patient histories and this supported staff to understand the needs, wishes and preferences of patients.

Patients who did not have family and friends to support them, where supported by advocacy services based on site and this also ensured that the patients voice was heard.

Requires improvement

Wards for older people with mental health problems

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

Average bed occupancy from 1 March 2016 to 31 August 2016 was 98% on both units; neither unit had vacancies available and were unable to admit patients from the local community. However, patients are not moved between units and their own bed remains in place when they return from leave.

In the last six months there had been six delayed discharges (three per unit). The Retreat York said that this was because of a lack of appropriate and safe placements in the local community for these patients and that they continue to work with the local authority and commissioners regarding this issue. The average length of stay for both units was significant at 6.8 years on the George Jepson unit and 6.1 years on the Katherine Allen unit. Both figures are significantly above the national average. Patients who remain on inpatient units longer than is necessary can become increasingly difficult to move on, they can become institutionalised, less likely to return home and develop new symptoms of illness hampering their recovery. Discharge planning was not embedded throughout the service. We saw on care plans that discharge was always mentioned but very rarely had firm plans been made for patients. Not all patients met the criteria for the unit and we questioned whether these patients were receiving the right kind of specialist care.

The facilities promote recovery, comfort, dignity and confidentiality

Both units had a full range of rooms available, such as a clinic room, and activity rooms. Patients were also able to use shared rooms in the main site to meet visitors and attend activities. However, on both units the dining rooms were not sufficient to allow all patients to be seated at one time.

Patients had access to outside space on the George Jepson unit directly from the unit. However, access was via a locked door and patients were unable to access outside without support from staff. The Katherine Allen unit did not have its own garden space due to its location on the first floor of the building. However, with staff support patients were able to use the extensive grounds in which the hospital is situated.

Patients had been given opportunity to personalise their bedrooms and we saw evidence of this during our visit. Staff had also made the units more homely for patients by decorating the environment with memorabilia and soft toys.

Since the last inspection, both units had put efforts into planning activities for patients. Both units had allocated occupational therapists, activity workers and volunteers. Patients had access to an activity schedule on both units, which was planned for seven days per week. On George Jepson unit there was an activities board, which listed group activities such as gardening, crafts, baking, board games, chair exercises, films, dominos and bingo. Patients were engaged in one to one work with occupational therapists and volunteers going out on trips and planting bulbs. However, during our visit to this unit we saw that two of the planned activities were not taking place as scheduled. During one morning we spent two hours on the unit and observed three patients sleeping in the main corridor in chairs and beanbags, two hours later these patients were still in the same position. We reviewed the activities charts for three patients and these charts started that patients were sleeping for most of the day. Staff had recorded on one day that a patient slept in the corridor from 12pm to 9.15pm, and recorded that another patient had sat on the main corridor from 11.30am to 7.15pm with no other activity recorded. Occupational therapists told us that this was a recording issue and that activities were taking place. However, we observed staff who were watching patients from their zonal observation points but were not engaging with them during these observations. Activities were taking place on a one to one basis but group activity and meaningful engagement were not embedded on this unit.

On the Katherine Allen unit, there were planned activities taking place during our visit. Unit activities included flower arranging, crafts and sensory groups.

Meeting the needs of all people who use the service

Requires improvement

Wards for older people with mental health problems

Both units were able to meet the needs of patients who required disabled access and equipment. The George Jepson unit was located on the ground floor and level access throughout. The Katherine Allen unit was located on the first floor but accessible via a lift and had spacious corridors, which we witnessed in use by patients who were wheelchair users.

We saw information leaflets in unit packs but did not see them on the unit. Staff told us these leaflets were available if required by a patient. Staff told us that they would access interpreters or signers as required initially via telephone support but could book one to one sessions if required.

The Retreat York had a chaplain who visited the units and provided support to patients as required. Patient's spiritual needs were considered throughout their admission and we saw that some patients were supported to attend church as requested. On the George Jepson unit a patient was being supported to practise home visits in preparation to return home for Christmas. Care was personalised and we saw examples of staff considering patients spiritual needs and beliefs and incorporating these into their care.

Listening to and learning from concerns and complaints

The Retreat York received 23 complaints in the last 12 months. However, only one complaint related to older peoples services and was about the George Jepson unit. This complaint was upheld by the service. The complaint related to the loss of an orthopaedic chair, poor communication and transfer. The provider accepted that communication around transfer was unsatisfactory.

We reviewed five complaints from across the organisation during our inspection. We found the complaints process to be clearly defined with distinct timescales; the chief executive of the organisation signed all complaints. However, the recording of verbal complaints on the units was less clear. Patients would have to telephone the risk department, who triaged complaints, rather than unit staff recording the details. We also found limited evidence that people were supported to complain; people were not reminded that they or their loved ones' care would not be compromised. It was not clear that people were offered the choice to keep their complaints anonymous or that all investigators had been trained in root cause analysis. Learning was fed back via the provider's sharing and learning bulletin and quarterly reports.

The George Jepson unit had recorded 8 compliments in the last 12 months, and the Katherine Allen unit had recorded six compliments.

The service had a strong ethos of the use of advocacy to support patients who were unable to voice opinions without support. Patients were encouraged to give feedback and to do so with the support of an advocate.

Staff told us that they were concerned about how they received feedback from senior managers should a complaint be made about them. Staff said that they were concerned about a blame culture within the organisation and that they did not feel supported if mistakes were made. However, staff told us that this was a historical issue and that they felt listened to in recent weeks and hoped that this would improve. The management team were aware of staff concerns and the chief executive was working with the senior management team to address the historical culture of the organisation.

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

Good

Vision and values

The Retreat York's values were:

- Equality and community
- Hope
- Care for our environment
- Peace
- Honesty and integrity, and
- Courage

Staff we spoke with understood these values and told us that the value base within the service was embedded and discussed on a regular basis. Staff told us that they needed to be fully aware of and willing to work within the organisations values to work within the hospital because the values were very important to the organisation, the patients and the staff.

Staff knew the most senior managers in the organisation and told us that they saw them on a regular basis. Staff told us that the newly appointed chief executive had worked some shifts on the units to get to know staff and patients, and they felt that she had an open door policy.

Requires improvement

Wards for older people with mental health problems

Good governance

There were some issues with the providers overall governance system and its monitoring of the service.

Mandatory training figures were lower than the internal provider target. During the inspection we did not see evidence that these lower levels of training compliance were having an impact on direct patient care. However, patients may be placed at risk if not all staff are trained in fire safety. The provider was aware of the need for action. Not all staff on the units for older people had undertaken specific training in the care of patients with dementia. The psychologist had recognised this need and was beginning a programme of in-house training.

Supervision and appraisal were not taking place as per the provider's own policy, on George Jepson unit less than 60% of none medical staff had an appraisal and less than 65% on the Katherine Allen unit. When staff are not effectively supervised and appraised, they are not offered the opportunity to discuss how to improve performance and identify training and development needs. Managers are also unable to share concerns about performance or give updates on lessons learned and service development. However, staff told us that they felt supported by their managers at unit level and had the opportunity to attend group supervision sessions as required.

Both units used bank and agency staff to support patients. This was higher on George Jepson unit because this unit also had a high number of vacancies for qualified nurses. The unit had a high staff turnover in the last twelve months which had led to staff shortages and the use of bank and agency staff. Katherine Allen was a more settled staff team. On the George Jepson unit, 29 shifts had not been filled between March and August 2016. Patients may be placed at risk when staffing numbers do not meet the appropriate levels. However, we did not see that lower staffing numbers had a direct impact on patient care during this period of time.

Staff were undertaking clinical audits on each unit and the provider supported the units by undertaking overall audits of areas such as the Mental Health Act. However, the organisation was not taking part in peer review schemes which would support them to identify improvements in practice.

Staff told us that in recent months, administrative support had been removed from the units. This meant that staff were spending more time on administrative tasks and they felt that they had less time to spend on direct patient care. We saw evidence that this was the case on George Jepson unit were group activities were not taking place as planned. This also affected patient care because paperwork needed for patient care was not filed correctly as it awaited scanning in a large backlog. The chief executive told us that they were re-evaluating the restructure based on staff feedback.

Staff had good knowledge of safeguarding procedures, reporting procedures and how to identify abuse. Staff had been trained in and evidenced a basic knowledge of the Mental Health Act and Mental Capacity Act.

We saw evidence that both units were measuring team performance and reporting on a quarterly basis. Easy to read documents were displayed on notice boards on units and identified the number of complaints, audit results, incidents, medication errors and compliments per unit. They summarised outcomes and results.

Units had specific objectives they were working towards:

George Jepson

- Clinical model to be implemented
- Training matrix to be developed
- Dementia friendly environmental work to be completed

Katherine Allen

- Ensure a dementia friendly environment e.g. lift flooring
- Review delivery & recording of meaningful engagement
- Improve staff awareness and understanding of Mental Capacity Act

Unit managers told us that they did not have access to sufficient admin support following a recent review of arrangements. However, they did feel that they had sufficient authority to do their job and that this had improved in recent weeks and they had been given further autonomy over staffing requirements.

Unit managers told us that they were able to submit items to the provider risk registers when they were concerned.

Leadership, morale and staff engagement

The annual staff survey was completed in May 2016 but related to The Retreat York as a whole rather than to this core service. Key themes for action were:

- Communication

- Leadership
- Pay and benefits

The provider had an action plan in place to review the above themes in the hope of a more positive response to the staff survey in 2017.

Sickness and absence rates were below the organisations target of 3% on both units. However, there had been an issue with staff retention on both units. George Jepson had nine staff leavers in the last 12 months (35%) and Katherine Allen had six staff leavers in the last twelve months (21%).

During the inspection, staff morale was low on both units. Staff told us that they felt supported by management at a unit level. However, they said that low morale was due to fear of victimisation and blame should something go wrong. Staff were able to give examples of times when mistakes were made and that an individual staff member had felt blamed by the senior management team. Staff said that because of this they would be reluctant to report mistakes. The CQC have received several whistleblowing complaints relating to these units in the last 12 months, staff told us that this was because they did not feel able to talk to the senior management team so referred immediately to us. However, staff told us that in recent weeks, the newly appointed chief executive has been a positive influence and has listened to staff concerns and they feel that a difference will be seen. The chief executive confirmed that she had met with staff and was addressing the cultural issues in the organisation.

Teamwork was evident throughout the inspection when we spent time observing staff on both units. Staff were supportive of each other and offered help to ensure the best outcome for patients. Staff told us that they felt supported by their colleagues and the wider multidisciplinary team and told us that the other disciplines in the multidisciplinary team such as doctors were approachable and could always be contacted for advice. It was evident when observing staff with patients that they enjoyed their jobs and were compassionate towards the patients they were working with. Unit managers were supportive of their teams and passionate about how hard staff worked with patients.

With some explanation, staff were aware of the duty of candour and their responsibility to patients and their families to explain when things have gone wrong. We saw that duty of candour was incorporated into the incident management system and safeguarding referrals.

Commitment to quality improvement and innovation

Katherine Allen unit had been accredited to the Accreditation for Inpatient Mental Health Services - Wards for Older People (AIMS-OP) scheme. The certificate runs from 03 April 2014 until 05 June 2018. Accreditation for Inpatient Mental Health Services- Wards for Older People works with wards providing services to older people to assure and improve the quality of inpatient mental health services. It engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement. This accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided.

Older adults services were actively involved in clinical research, peer reviewed research papers and invited to present at conferences. One of the clinical psychologists had two published journal articles in 2016 on the topics of dementia and older adult recovery.

George Jepson unit was not accredited with any quality improvement or peer review schemes.

Provider level governance

Quarterly review reports collated by the risk team and safeguarding team and were sent to unit managers, discussed at clinical governance meetings and reviewed at quarterly board meetings. Incident reporting was thorough and was discussed daily at ward level and quarterly governance panel meetings. We reviewed an action plan tracker to monitor actions and meeting minutes where panel members had signed off the root cause analysis of the incidents; we were told that numbers of staff trained in root cause analysis was highlighted on the risk register. Lessons learnt from complaints, incidents, clinical audit and internal key lines of enquiry inspections were communicated in clear summaries via monthly bulletins and monthly unit reports. Staff at unit level were unaware of feedback from investigations via this process though admitted learning was discussed at team meetings.

Requires improvement

Wards for older people with mental health problems

We reviewed the five most recent safeguarding concerns raised and the five most recently closed safeguarding for the organisation. We found there to be thorough investigations, methodical reviews and clear documentation. We saw discussion with patients, use of the cognitive behavioural therapy model 'ABC' which identified the activating event, beliefs and the consequences of the event. We spoke with the safeguarding lead and saw minutes of safety planning meetings having been held, risk management plans and observation plans for patients completed. Safeguarding records also referred to the duty of candour responsibilities and discussion at quality meetings. We found there to be good links with the local authority and the local authority confirmed a close working relationship.

The organisation had a duty of candour policy that detailed the organisational approach to duty of candour. We reviewed this policy during our inspection. Duty of candour was discussed at unit managers meetings and if incidents warranted investigation, the chief executive officer and registered manager were informed. Unit managers provided explanations verbally and in writing. A duty of candour log was kept on the shared drive and was reported to the Governance Committee.

We reviewed six staff personnel files. Files included appropriate documentation for example; appraisals, contracts and job descriptions, copies of applications, professional registration where appropriate and reasons for gaps in employment. We did not see references or photographic identification for one staff member, although they did have non photographic identification in the file. One file did not include Disclosure and Barring Service (DBS) information; this information helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. One file was also missing an occupational health self-assessment. Files were stored securely and were clear to navigate.

Appraisal rates for the provider were low; 63% across all units including allied health professionals and management staff. Management levels were 33% and the provider told us that senior directors were not appraised. Kemp unit figures at 11% were evaluated separately because staff were still in their probationary period as the unit had opened in May 2016. The provider was aware of the rates and committed to all unit staff having completed appraisals by the end of January 2017. Supervision rates were low on the units and did not adhere to the provider's own policy. Staff on the Katherine Allen unit and Kemp unit did not receive individual clinical supervision on a regular basis. This meant that there was a reduced opportunity for staff to learn and develop their skills. All services held weekly group supervision.

A provider is required to complete checks on its directors to ensure they meet the requirements of the fit and proper person test. We reviewed five director level personnel files to verify that these checks had been undertaken. Three files were complete however two files were missing disclosure and barring service information; one file referred to a disclosure barring service check having been undertaken but there copy in the file and another included no disclosure barring service check or references. Whilst we were not aware of any issues in relation to the conduct or competency of the individuals, it is the responsibility of the provider to have systems in place to ensure these check are carried out.

As part of this inspection, we undertook a review of the implementation of the Workforce Race Equality Standard. The Workforce Race Equality Standard is a mandatory requirement for organisations that receive at least £200k of their aggregated annual income from NHS-funded care. Organisations are to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve black and minority ethnic board representation. The provider described the difficulty in positively recruiting a diverse group of staff and had advertised nationally as a way to increase diversity with little success. They were equality delivery system 2 compliant and we saw that details of ethnicity, disability and gender were incorporated into the finance and resource committee report. However, no mechanism was in place to identify and publish progress against the nine indicators of workforce equality at the time of our inspection.

The organisation had recently completed a voluntary redundancy scheme to increase efficiency and financial position. Nursing and support staff were ring-fenced to ensure patient safety. We spoke with an organisational consultant employed by The Retreat York to manage the change alongside the provider's organisational change lead at the time who said that staffing levels had been set

by the previous leadership team. During the inspection, we identified that there were issues with administration and maintenance not being completed in a timely fashion due to a restructure of ancillary staff. All units described the loss of dedicated ward clerks and increased workload as a result. We saw delays in blood results being updated on the electronic record keeping system. Administrative staff lost 3.4 whole time equivalents through the voluntary redundancy process. The chief executive was aware of the issues caused by the recent restructure and was reviewing the administrative support and staffing levels.

The maintenance team lost 5.8 whole time equivalents through the voluntary redundancy process. The provider had arranged two contacts with external contractors from October 2016; one for lift maintenance and the other alarm contracts. Maintenance staff told us that there was no cover when they were off sick. During our inspection access to Naomi unit was difficult because the doorbell was broken. Although patients and staff had access to the unit via key fobs we later discovered that the doorbell was not linked to the nurse's station and when it had been fixed, staff could still not hear it. Naomi staff told us that they had raised not being able to respond from the nurses unit with the senior management team when relocating. Domestic staff had lost 2.3 whole time equivalents and although the units were clean, domestic staff were not able to audit cleanliness as frequently as a result.

Staff also raised concerns regarding the change to the dedicated psychology and occupational therapy support on each unit. There was no psychology clinical lead at the provider since they had left three months previously. Staff were concerned that they could not offer the same level of knowledge and support to patients and it was unclear how they would attend multiple multidisciplinary team meetings.

We spoke with the acting finance director and the chief executive of The Retreat York regarding the recent changes in ancillary staffing. They confirmed that they were conducting a review based on staff feedback for staffing in administrative areas and that an additional two domestic staff had been employed prior to our inspection.

Specialist eating disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are specialist eating disorder services safe?

Safe and clean environment

Naomi unit is located on the second floor of the main building. The unit had a stair lift to allow access from the ground floor. Patients and staff had a key fob to access the unit. Naomi unit had a multidisciplinary team office, a multipurpose room, a group room, small homely lounge, two therapy rooms with viewing panels controlled from the outside and a locked rehabilitation kitchen. Patients were able to access an additional kitchen area at all times. The unit also had a laundry room, arts and craft room, rest zone, and a small dining area that was not adjacent to the kitchen; meals were delivered on a trolley via the corridor. The unit manager told us that they hoped to get planning permission to create a larger dining room because space was limited if all patients and staff supervising meals were dining together. It was important to staff that patients felt comfortable in the dining room. Patients had access to a private garden, two smoking areas and a snoezelen room. A snoezelen room is a therapeutic environment created for the express purpose of delivering high levels of stimuli to patients. It displays optical illusions with combined lighting effects, smells, colours, textures and sounds that stimulate the patient. All bedrooms were en-suite and anti-ligature with the exception of two rooms; patients were risk assessed prior to admission to these rooms to minimise the risk of self harm. Two bathrooms were not listed on the environmental risk register; the toilet seats were not anti-ligature fittings. The unit areas were clean and well maintained and patients were able to personalise their bedrooms.

The existing layout did not allow staff to observe all parts of unit. The unit had long corridors with many corners and turns. Staff monitored the risks with regard to ligature points and blind spots within the local unit risk register and regular environmental risk assessments were undertaken. A ligature point is something, which people can use to tie something to in order to strangle themselves. The provider had further mitigated risks through a new environmental observation protocol where a staff member, normally agency staff, conducted 15 minute checks of the environment and updated the environmental risks recording sheet as well as updating staff of risks at handover. We observed this to be the case during our inspection. We saw that a new member of agency staff received a thorough handover and the nurse arranged for a local unit induction when the handover finished. Risk was also managed through individual patient observation levels. A recent Quality Network for Eating Disorders review suggested that mirrors be installed to further minimise risk from blind spots. The Naomi unit also had three apartments with one bedsit for patients to progress to as they were further long their pathway of care. These were not included in the environmental observations as patients were deemed lesser risk of self harm.

The unit was female only and had no seclusion facilities. There was a new alarm system in place and staff carried personal pagers. Nurse call systems were available in patient bedroom, corridors and in all communal areas of the building.

There was a well-equipped, clean and organised treatment room with accessible resuscitation equipment; emergency drugs were checked regularly. However, the electronic suction pump and electrocardiogram machine lacked check stickers making it difficult to tell when the equipment had been last calibrated. There was one electrocardiogram machine shared by all six units at The Retreat York and another Retreat site 30 minutes away. An electrocardiogram checks the heart's rhythm and electrical activity. It is used to diagnose and monitor conditions that affect the heart. We asked staff about access to the

machine and they confirmed that they would dial 999 in an emergency. The clinic room had an examination couch. Hand washing facilities and notices were present through the building and alcohol gel dispensers were placed in doorways, the clinic room and the dining room. We viewed a completed hand hygiene audit. Medicines were stored securely and access was restricted to authorised staff. Room and fridge temperatures were recorded daily and were within the recommended ranges.

Safe staffing

The nursing establishment whole time equivalents on Naomi unit between 1 June 2016 and 30 August 2016 was:

- Qualified nurse whole time equivalents: 11
- Support worker whole time equivalents: 15
- Number of vacancies – qualified nurse whole time equivalents: 1
- Number of vacancies – support worker whole time equivalents: 2
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 24
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 2
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 0

Daytime staffing was two qualified nurses and four support workers, night-time staff was one qualified nurse and two support workers. Although there were additional staff disciplines on the unit such as psychologists and occupational therapists for individual and group work who offered support, patients and staff both felt more staff were needed. Total numbers of substantive staff between 1 September 2015 and 31 August 2016 was 29; seven staff left during this period however three more staff were scheduled to start. The overall staff sickness for the organisation was 3% between 1 September 2015 and 31 August 2016. The provider provided staff sickness figures for the previous 12 weeks; Naomi unit had rates of 1.5% well below the provider's target. Five staff spoken with described a shortage of staff on the unit and one member of staff told us that one group was cancelled in the past month because of insufficient staff. One member of staff declined to comment on staffing shortages. Staff also described difficulties in organising trips and leisure activities for patients. Patients on the unit agreed that staff cannot always respond due to staffing levels but they did have regular one to one time with their named nurse and support worker. We asked the provider the number of occasions that section 17 leave had to be cancelled due to short staffing; they told us that it had not occurred. Naomi unit uses bank staff where possible before asking agency staff to cover shifts. This is beneficial for the patients as staff and patients are familiar with each other and the unit; bank staff also received the same training as permanent members of staff. The unit manager confirmed that they were able to adjust staffing levels daily to take account of the skill mix. However, explained that since all unit clerks had been reassigned to pooled working, this had affected the medical staff and unit managers' workload. Patients and staff reported that staff had been moved to cover staffing shortages on another newly opened unit. We asked The Retreat York for details relating to staffing movement between units but this was not recorded centrally. Staff told us that there was adequate medical cover day and night, and that a doctor could attend the unit quickly in an emergency.

Staffing establishments were set by the leadership team in line with NHS England guidance. We viewed 12 weeks duty rotas on Naomi unit. Staffing levels were able to be adjusted taking into account bed occupancy, new admissions and periods of one to one observations, however they did not always meet the provider's establishment as staff were not always available to cover any gaps.

The Naomi unit followed the mandatory training as set by the provider. Average training compliance was 86% which is above the provider target of 80%.

The following courses were below the target:

- Fire Safety: 70%
- Introduction to Information Governance : 69%
- Prevention and management of violence and aggression Level 3: 65%
- Professional Boundaries: 47%
- Prevention and management of violence and aggression Level 2: 0%

Of the courses below target The Retreat York confirmed that prevention and management of violence and aggression Level 2 is currently only assigned to staff as a reasonable adjustment when they are physically unable to do the full prevention and management of violence and aggression course (Level 3). Level 3 prevention and

management of violence and aggression is below the provider target at 65% and the provider was aware of this and addressing this issue. Professional Boundaries was an updated course rolled out at the end of 2015 and training figures were 47% Fire Safety is an annual statutory course and the percentage of staff completed was 70%; this is particularly relevant to the Naomi unit as evacuation would be from the first floor where it is located and one patient was noted to have mobility issues during the inspection.

Assessing and managing risk to patients and staff

There was one incident of restraint reported from 1 March 2016 and 31 August 2016. No rapid tranquilisation or prone restraint, (when the patient is restrained face down), were used on this instance. The Retreat York reported no incidents of seclusion or long term segregation between 1 March 2016 and 31 August 2016. The provider had set up a task and finish group in September 2015 to look at how to reduce the restrictive interventions across the organisation in line with Positive and Proactive Care guidance. The task and finish group met for five meetings and developed an action plan that was reviewed in the organisation's care programme approach meetings. The care programme approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

On admission, staff completed a functional analysis of care environments risk assessment for the patient. The functional analysis of care environments risk profile was included in the Department of Health's published guidance 'Best Practice in Managing Risk' (March 2009). Staff completed a further risk assessment every three months unless the individual patient circumstance meant more were required as per the provider policy. We viewed six risk assessments during the inspection and saw this was the case. We observed one handover where past and current risks were discussed and documented in advance of the meeting. Risk was also discussed in multidisciplinary team meetings, formulation meetings and handovers should an incident occur and review of risk be required.

Patients on Naomi unit had fob access to enter and leave the unit however we found the activities daily living kitchen to be locked. Patients had to ask staff to unlock the door and their individual risk was not considered.

Staff were trained in safeguarding and knew how and when to make a safeguarding alert. Staff described when to raise a safeguarding, including domestic staff and maintenance staff who worked on the unit. They described how they alerted the lead nurse and contacted the social work team who lead on safeguarding in the Retreat York. Staff asked patients if they wished to raise issues like bullying from other patients as safeguarding and would offer support if no formal safeguarding was raised. Safeguarding was clearly embedded across the service. There were good links with the local authority, confirmed by the local authority, and staff and care and treatment records reflected safeguarding concerns. All staff had completed Child Protection Core Level 3 and Safeguarding Adults General Awareness training and 90% of staff had completed Child Protection Level 1 Basic Awareness training.

We reviewed 10 charts and found medicines were stored securely and access was restricted to authorised staff. Room and fridge temperatures were recorded daily and were within the recommended ranges. There were facilities to store and record controlled drugs and these were appropriately managed. Medicines information leaflets were available for patients to read when new medicines were prescribed and patients could meet with a pharmacist. Medicines reconciliation was completed for all new admissions by the technician led service medicines code and rapid tranquilisation policies were reviewed annually by the designated pharmacist. The pharmacy received, actioned, and disseminated medicines alerts and recalls and this was appropriately managed. Medicines incidents were broken down into core areas and were analysed by the pharmacy department. All incidents were reviewed in the clinical governance group as a standard agenda item and a pharmacist attended these meetings. Learning from incidents was shared and we saw how controlled drugs incidents had prompted a training package being developed.

The Retreat York had a children's visiting area available in the shared area in the main building which could be used should relatives bring children to visit patients.

Track record on safety

There had been four serious incidents requiring investigation as reported by the provider between 3 September 2015 and 5 August 2016. One patient had self harmed, one patient raised concerns at being alone, one patient had alleged abuse after absconding and another

concerned verbal abuse by a visitor. We viewed care and treatment records and could see that thorough investigations had been completed but could not see evidence of changes being made as a result.

We asked staff if they felt confident in raising issues and concerns about care and practice with senior management teams. Staff told us that they felt comfortable and supported at a local level but would not feel confident taking issues to the senior leadership team because they worried about repercussions. However, staff told us that since the new chief executive arrived in post they felt more comfortable raising concerns.

The unit worked as a therapeutic community and patients and staff discussed incidents and solved problems as cohesive group at daily meetings. Emergency meetings were also scheduled if needed.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and were able to tell us the process. Staff reported incidents to the safeguarding team, completed electronic incident reporting forms and incidents were noted on handover sheets and discussed. Incident reporting forms incorporated a duty of candour section and staff were aware of the provider's policy and their responsibilities within this requirement. The organisation had a duty of candour policy that detailed the organisational approach to duty of candour. We reviewed this policy during our inspection. Duty of candour was discussed at unit managers meetings and if incidents warranted investigation, the chief executive officer and registered manager were informed. Unit managers provided explanations verbally and in writing. A duty of candour log was kept on the shared drive and was reported to the governance committee.

The incident reporting form automatically updated the managers and department leads. Unit managers took all incident reports to the morning managers meeting for review and discussion, which allowed them to obtain advice and support from other managers.

Patients of the service told us that they felt the service was open and willing to discuss any concerns or difficulties and work through them. A member of nursing staff described emergency meetings and informal discussions of incidents at the daily morning meetings but highlighted that bank staff were not usually involved. The Retreat York confirmed that lessons learnt were reported back to staff via monthly bulletins however two nursing staff were not aware of feedback from the investigation into incidents; one recollected that they may have received an email but was not sure. Staff could not provide an example of changes being made on the unit because of incidents or describe a formal post incident staff debrief, although one nursing staff did say that they were a supportive team who informally talked through any issues.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

We viewed six patient care and treatment records that were stored on the electronic record system. Agency and bank staff had user accounts and were able to update the system. Of the six records we found only one that had been regularly updated. One patient waited two weeks before their care plan was completed on the system. We found that all patients had received a physical assessment on admission. However. These assessments were not always recorded in the system consistently; one patient's physical checks were recorded on the initial assessment paper file. A general practitioner doctor visited the unit twice a week; they did not have access to the electronic record system, consequently a paper record was kept in a separate file. Staff told us that scanning the notes onto the electronic record was historically completed by the unit clerks. However, since a restructure of the administration staffing, it had now become the duty of the night staff. We were told and observed that daily blood tests could sit for five days before being recorded on the system. The consultant psychiatrist on the unit would telephone the local hospital for the results to ensure they had the most up to date information. Two members of staff could not locate physical health records on the electronic system when asked but did find another member of staff who could.

Records were not holistic or written in the patient's voice but they were individualised. Two patients had a 'respect my wishes' document in their plan. We reviewed one record where patient views were recorded on the multidisciplinary team review form but the care plan did not show evidence of personalisation. One record referenced the National Institute for Health and Care Excellence guidelines which

are evidence based national guidance. We saw that two of the six care and treatment plans had crisis plans in place; one was started but not completed and three had no crisis plans visible. Crisis plans allow staff to know how best to look after patients when in crisis.

Best practice in treatment and care

Naomi unit used a cognitive behavioural therapy based model, called 'pathways to recovery' based on National Institute for Health and Care Excellence guidelines for the treatment of eating disorders, mood and anxiety disorders (Eating disorders in over 8s: management - CG9). The electronic system supported staff by pulling this guidance into individual care plans. Medicines related care plans did not always provide detailed information about dosages or patient preference for administration. For patients with multiple medicines no written guidance was available as to which item was to be given first or when to administer the second item. Administration codes were used for missed doses however reasons for code use were not documented and any actions taken were not recorded.

Staff were present at mealtimes and supported patients to eat and drink. This meant that risks were monitored and staff were aware of patient's food and fluid intake. One nurse described how meal plans and support were created for the individual's dietary needs and that the Naomi unit pathway is a psychotherapy model. Psychosocial activities included, core shop and cook, life skills, foundation skills group, advanced and core cognitive behavioural therapy groups. The unit had a separate eating disorder nutrition risk screening tool and there were close links with the local acute health trust. Patients also had access to food, drinks and snacks throughout the day and we saw that staff offered patients a choice of meals.

Staff used Health of the Nation Outcome Scales to assess and record severity and outcomes and the Waterlow score to estimate risk of the patient developing pressure sores.

Staff could not provide details of clinical audit on the unit but they had recently received an updated environment and facilities re-audit from the Quality Network for Eating Disorders after relocating to the second floor. We also saw evidence of staff completing care plan audits as part of the provider's quality review of 19 standards based on National Institute for Health and Care Excellence (NICE) guidance.

Skilled staff to deliver care

The service medical cover comprised of consultant psychiatrist and an on call system shared amongst The Retreat York's psychiatry consultants. There was no junior medical cover to support the psychiatrist. Staff described how they would telephone the psychiatrist out of hours for advice as well as the on call doctor. There was an induction programme for all staff, which included e-learning and face to face training. Support worker training also covered aspects of the support worker care certificate. Staff were experienced and qualified to perform their role; they had completed mandatory training which was specific to their role. Mandatory training was above 75% on all but four courses on Naomi unit.

There was no external specialist eating disorder training for staff. Access to external courses was described as difficult. Staff told us of the non-mandatory internal training that was available; such as physical health training, nutrition, boundaries, introduction to eating disorders, portion training, compassion focus training and training on cognitive behavioural therapy skills. These courses were delivered every six months by the nursing staff and the unit's consultant psychiatrist to new or inexperienced staff.

The provider submitted appraisal data for the period 01 September 2015 to 31 August 2016 prior to the inspection; 59% of non-medical staff had received an appraisal during this period. The provider emphasised that all other staff had an appraisal date scheduled for January 2017. An effective appraisal system improves performance and patient outcomes and we saw evidence that appraisals were not a priority. Doctors on the unit had been revalidated.

Qualified nursing staff explained that group supervision sessions took place for one hour each week. However, allied health professionals did not have access to supervision as frequently. One staff member explained that the frequency of their individual clinical supervision had improved from every two to three months to every six weeks. Another allied health professional described that supervision had ceased when there had been a change in manager; as a result they sought support from an external source.

Multidisciplinary and inter-agency team work

Naomi unit worked with a multidisciplinary team, which included nurses, support workers, psychiatry, psychology, cognitive behavioural psychotherapy, dieticians,

occupational therapy, advocacy, involvement worker, pharmacists, physiotherapy, and social workers. A multidisciplinary team meeting was held twice a week on Naomi unit.

We observed a handover meeting in which all patients were discussed, updates from the multidisciplinary team, historical and present risks were discussed and we saw a supportive attitude from the staff attending. Staff also completed a communications book and had comprehensive handovers for each shift. Patients and staff were both involved in care programme approach meetings.

We did not find consistently effective links with other organisations in terms of discharge planning. One patient had not met with their home treatment team and was unclear as to their care package, even though they were due to be discharged soon. Staff described involvement from external organisations was difficult as patients were admitted from all over the country. However, we found The Retreat York's social worker team were highly involved and patients had good links with local social services, particularly in terms of safeguarding.

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

Staff explained the role of the Mental Health Act advisor in The Retreat York and knew how to make contact for any support. Staff also described that the Naomi unit emphasis was working with patients on a voluntary basis but occasionally patients were detained. There were no detained patients on the unit when we inspected. Informal patients received a leaflet regarding their rights and conversations with patients were led by nursing staff. The Mental Health Act advisor produced twice yearly bulletins that were emailed to staff to update any changes in policy or law.

All staff had received training in the Mental Health Act; this was part of their mandatory training and was scheduled to be refreshed every three years. We spoke with the Metal Health Act advisor who confirmed that the updated code of practice had been incorporated into the mandatory training provided and an additional session was held for staff in regards to the updates.

The Mental Health Act advisor had comprehensive monthly audits in place for use of urgent treatment, holding powers and temporary holds on informal patients. The provider's audit manager conducted additional audits including confirmation that the hospital had given information to detained patients, leave of absence from hospital and consent to treatment.

Patients accessed an independent mental health advocate via local advocacy services. They are trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the Act and participate in decisions about their care and treatment. We observed advocacy posters with contact details on the unit however contact details were not included in the unit welcome pack.

Good practice in applying the Mental Capacity Act

On Naomi unit 98% of staff had received mandatory training in the Mental Capacity Act. There was a Mental Capacity Act and Deprivation of Liberty Safeguards policy available on the provider's shared network to refer to. Staff explained that patients on Naomi unit generally had capacity and one nurse described a previous occasion where they had to complete a capacity assessment. They felt fully supported and the on call doctor came in to talk the nursing staff through it. Staff also explained that they contacted the Mental Health Act advisor in The Retreat York for any support. Staff were seen to have a good understanding of Mental Capacity Act 2005 and could describe the five statutory principles which were also displayed on a notice board in the staff room.

We viewed six patient records and saw that patients signed a consent form for informal admission. There were no formal capacity assessments and staff explained that they presumed capacity unless there was a reason to question it. There was one incident of restraint reported from 1 March 2016 and 31 August 2016; staff were trained to work in the individual's best interests, using the least restrictive option for the minimum amount of time.

Adherence to the Mental Capacity Act within the service was monitored via the audit lead at the Retreat York.

Are specialist eating disorder services caring?

Kindness, dignity, respect and support

We observed staff and patient interactions during the inspection on Naomi unit. We saw staff being respectful

and courteous at all times. We observed patients having lunch and attended a post lunch support group; the group was led by the patients and staff joined in towards the end to help solve any unresolved issues.

We spoke with six patients on the unit. They all said they felt safe on the unit but felt that there was not always enough staff available. One patient told us that a murder mystery night was cancelled as the staff member allocated to the activity was sent to cover a shortage of staff on another unit. Patients described the new environmental observations and commented on their irritation with the increased monitoring. Five patients described the staff as amazing and explained how they felt valued and supported by them. They were happy and confident that their physical and psychological needs were being met. Patients said staff were professional, kind and respectful of their personal space.

The involvement of people in the care they receive

We saw that all patients received a patient information pack which contained useful information for example, a description of the service model, the philosophy of the unit, compulsory groups with timetable, details of the roles of the multidisciplinary team, smoking arrangements, contact with families and friends and information on how to make a complaint. All patients described that they had been shown around the unit at assessment but one patient explained that this had not reoccurred on admission. Patients also received a leaflet that described what to expect in the first 48 hours of admission to the unit. This included photographs of staff and the unit and described the facilities and admission process in a bite size document. A schedule for the day was also included.

We viewed six care and treatment records. Five of the records we viewed were individualised but not written in the patient's voice. One record indicated the level of the pathway but did not describe how that patient was to be supported. Two records included a 'respect my wishes' document that patients complete on admission; this identified how service users wished to be treated. Only one record indicated that the patient had been given a copy of their care plan but patients told us they could have a copy if they wanted.

We were unable to speak to carers and family members as part of the inspection. However, we viewed minutes from the quarterly carers focus group held by the involvement lead at The Retreat York. They described a lack of communication with carers, and some were unclear about their family member's recovery pathway and key contacts. We noted however, that some actions from the meeting had been completed and there was now a carer information board on the unit. One patient spoke positively of their family coming to visit and going for a meal with them in the community. Patients confirmed that families were involved in their care if they wished and we saw contact details in patient care and treatment records.

Patients accessed advocacy locally and patients were actively involved in staff recruitment and decisions which affected the service. Patients had daily meetings and one patient described how a complaint to the service had been properly investigated and that they had received feedback. One patient explained how they had been involved in choosing the furniture for the move to the new unit.

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

Access and discharge

The average bed occupancy of Naomi unit for the period between 1 March 2016 and 31 August 2016 was 83%. When patients went on leave they were able to return to their rooms.

Patients were admitted on Monday mornings which allowed for physical monitoring and tests to be completed. Patients were discharged or moved at an appropriate time of the day. There had been one discharge on Naomi unit between 1 March 2016 and 31 August 2016. This discharge was against the advice of the clinician and the patient was readmitted seven days later following a re-assessment and agreement from the home care team and NHS England.

The provider explained that when a patient required a transfer to a psychiatric intensive care unit or acute mental health environment, they liaised with the patient's home team care coordinator and local crisis home treatment team. They confirmed that delays can occur as local trusts cannot identify a bed immediately due to national shortages.

We reviewed six care plans and saw that one record had evidence of discharge planning recorded in the care

programme approach meeting minutes but not in the care and treatment record itself. One patient was discharged during our inspection and had had their discharge care programme approach meeting prior to our inspection. There was no record of this meeting on the activity record or meeting minutes. When discussed with the unit manager it was suggested that they were being written up but they could not confirm this.

The facilities promote recovery, comfort, dignity and confidentiality

Naomi unit had a full range of rooms available, including clinic room, therapy rooms, lounges and activity rooms. The unit also had a room where patients could meet with visitors. Patient belongings could also be secured in a locked drawer in their rooms. Patients described the food as excellent and explained there was a three week menu rotation.

There was a timetable of activities, which accommodated the changing needs of the patient group that included different therapy options appropriate to the individual, healthy eating groups, self-catering and community outings. There were optional groups that were also available such as going to the gym, swimming, yoga, trips out, gardening and the choir. There were no therapy groups at the weekend with the exception of the post meal support group. There was an activities board with activities seven days a week and patients were encouraged to go on trips off site at the weekend. Patients enjoyed accessing pet's corner where they kept and looked after a variety of animals; patients were able to bring their pets from home if they wished. Patients at The Retreat York also accessed animal therapy via a local charity on a monthly basis.

Meeting the needs of all people who use the service

Naomi unit had a stair lift to enable patients with mobility difficulties access to the garden and the rest of the grounds.

The onsite catering facilities and staff were able to meet dietary requirement needs of any religious or ethnic background. The lead chef at The Retreat York described how halal and kosher meals were prepared in a different manner for patients with different religious beliefs and that there was always a vegetarian option available. The dietician worked closely with the catering team. The chef told us that nine months ago, a patient was admitted with a nut allergy and the catering team had not been informed; immediate action was taken to meet the patient's dietary needs. On Saturdays patients were offered a cooked breakfast and Sundays and holidays were marked with traditional lunches. Patients were able to meet with the catering team and 20 patients attended the last 'meet the chef event'. The chef told us that a third of the new menu were patient's choices, some were traditional favourites and the chef's introduce new dishes for the patients to try on a regular basis.

There was access to a range of spiritual and faith support facilitated by the chaplain who was on site two and a half days a week. The chaplain incorporated different patient's faiths into services. The provider had a quiet room available for patients spiritual needs; it was intentionally not referred to as a prayer room as the room was available to all. We viewed a leaflet for patients that offered information and support for spiritual health at the provider. The chaplain told us that the provider runs an 'S-group', collectively the patients and staff look at the organisation's approach to spirituality. Patients and staff spoke very highly of the chaplain and explained the support that the chaplain offered. The Retreat York also arranged access to local churches for those patients who wished to attend services.

Information leaflets were available but we did not see leaflets in different languages. However, staff told us these were available if required by a patient. In order to communicate with non-English speaking patients the provider accessed a translator service via the telephone.

Listening to and learning from concerns and complaints

Patients knew how to complain and details of the complaints process was in the unit information pack, leaflets and feedback books were also viewed on the unit. The Retreat York's complaints policy accepted concerns via verbal, written or electronic means. There were five complaints in the last 12 months on Naomi unit; two complaints were upheld, two complaints partially upheld and one not upheld. No complaints were referred to the ombudsman. Staff and patients on Naomi unit felt inadequately consulted regarding the recent unit move. This resulted in staff and patients raising complaints around the environment.

We reviewed five complaints from across the organisation during our inspection. We found the complaints process to be clearly defined with distinct timescales; the chief

executive of the organisation signed all complaints. However, the recording of verbal complaints on the units was less clear. Patients would have to telephone the risk department, who triaged complaints, rather than unit staff recording the details. We also found limited evidence that people were supported to complain; Although we saw a complaints leaflet that said patient care would not be affected as a result of a complaint, we saw no further evidence in the complaints records reminding patients or families of this. It was not clear that people were offered the choice to keep their complaints anonymous or that all investigators had been trained in root cause analysis. Learning was fed back via the provider's sharing and learning bulletin and quarterly reports. One patient on Naomi unit described how a complaint to the service had been properly investigated and confirmed that they had received feedback.

Are specialist eating disorder services well-led?

Vision and values

All staff spoken to understood the vision and values of the provider. One support worker had suggested and led a two week programme emphasising the provider's values in the month prior to our inspection. This programme was received well by patients and staff and values were observed to be demonstrated. The values of The Retreat York are:

- Equality and community
- Hope
- Care for our environment
- Peace
- Honesty and integrity, and
- Courage

We could not find specific evidence detailing how individual team objectives reflected the organisations objectives however the values were embedded on the unit and were incorporated into the ethos of the units.

All staff spoken with knew who the senior managers were within the organisation and confirmed they were visible on the units. The new chief executive had visited and worked shifts alongside domestic and nursing staff as part of their induction to the service.

Good governance

The provider had a training manager who recorded mandatory training for each unit. Additional training was delivered by staff on the unit, however recording of additional training was not centralised. Staff spoken with agreed that they had access to internal training but not external training. We asked the provider for details of additional training for all units including Naomi unit. Staff spoken with agreed that they had access to additional internal and external training. Average mandatory training compliance was 86% which is above the provider target.

Although Naomi unit monitored appraisals and supervision attendance, we did not find it effective; staff described an improvement in frequency and support given but the release of staff to these activities was evidenced in the low appraisal rate and lack of consistency in supervision for all staff. There we no regular staff meetings, however, staff explained that they were comfortable raising issues with the consultant psychiatrist and manager of the unit.

Staffing levels were set by the leadership team according to NHS England guidance and were adjusted to incorporate patient observation levels. The unit manager and nursing staff confirmed that they had sufficient authority to increase levels when needed. Staff did however report that staff from Naomi unit had been reassigned to cover staff shortages on other units sometimes resulting in the cancellation of activities on the unit. There was a clear escalation procedure and staffing levels were checked against the rotas for each shift. The nurse in charge updated the unit's safer staffing board in accordance with any changes. Naomi unit used bank staff as the primary means of cover and agency usage was low.

The unit worked as a therapeutic community and patients and staff discussed incidents and solved problems as cohesive group. However, staff could not provide any example of changes being made on the unit as a result of incidents or describe a formal post incident staff debrief. Staff were able to submit items to the local and provider risk registers. Staff had good knowledge of safeguarding procedures, reporting procedures and how to identify abuse. Staff had been trained in and evidenced knowledge of the Mental Health Act and Mental Capacity Act.

We saw evidence that Naomi unit measured team performance and reported on a quarterly basis. Documents

were displayed on notice boards that identified the number of complaints, audit results, incidents, medication errors and compliments per unit. Naomi unit also had identified the following objectives to complete:

- Train staff to meet needs of increasingly complex clients being admitted e.g. knowledge and understanding framework
- Ensure unit meets environmental requirements for eating disorder quality network review

A recent restructure of administrative staff support had created an additional workload for the unit manager and nursing staff.

Leadership, morale and staff engagement

The annual staff survey was completed in May 2016 but related to the provider as a whole rather than services for personality disorders. Key themes for action were:

- Communication
- Leadership
- Pay and benefits

The Retreat York had an action plan in place to review the above themes in the hope of a more positive response to the staff survey in 2017.

Sickness and absence rates were below the organisations target of 3% the unit. There had been an issue with staff retention on the unit. Naomi unit had seven staff leavers (24%) from 1 September 2015 and 31 August 2016. Staff explained that it could be difficult to find cover when staff members were unwell.

Staff on Naomi reported good relationships with the unit manager and consultant psychiatrist and felt able to raise concerns without fear of victimisation. Staff described the whistleblowing process and had an awareness of the policy. However, staff also told us that there was a lack of trust in the previous senior management team which had resulted in staff feeling unable to speak up. Staff described a culture of blame and disempowerment, which still existed as a legacy of the senior leadership team. Staff explained that communication was poor under the old leadership team and rumours spread easily. All staff spoke of a more positive future with the new chief executive in post. Staff told us that the move upstairs to the new unit felt fast and didn't feel well thought through. The chief executive had been meeting with staff and was working with staff to create a more open culture.

Teamwork was evident throughout the inspection when we spent time observing staff on the unit. Staff supported each other and offered help to ensure the best outcome for patients. Staff told us that they felt supported by their colleagues and the wider multidisciplinary team. Staff spoke of their pride when helping patients and seeing patients leave the unit. They spoke in a positive manner about the service and described good working relationships on the unit. They described being proud to be working there.

Unit managers told us of opportunities for development and described leadership training led by an organisational development consultant who had originally been employed to help manage the voluntary redundancy scheme.

Staff were open and honest and could describe their responsibilities under the duty of candour when things went wrong. We saw that duty of candour was incorporated into the incident management system and safeguarding referrals.

Commitment to quality improvement and innovation

Naomi unit had previously been accredited as excellent by the Royal College of Psychiatrists Quality Network for Eating Disorder Adult Inpatient Standards (QED). The Quality Network for Eating Disorder Adult Inpatient Standard standards are designed to reflect the experience of people using the services and look at all aspects of the service. The accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided. However since the unit had relocated upstairs an environmental and facilities peer review identified issues with the layout of the unit.

Tier 3 personality disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are tier 3 personality disorder services safe?

Safe and clean environment

Kemp unit and Acorn unit were located on the ground floor of the main building. Spring Lodge was a separate building on The Retreat York site. All units had blind spots; areas where staff could not see patients at all times. This meant there was an increased risk of harm to patients because the units contained ligature points. A ligature point is something, which people can use to tie something to in order to strangle themselves. Unit managers told us that the risk was mitigated because all patients had individual risk assessments and staff were aware of the risks on the units which were regularly audited and entered on the risk register.

On Kemp unit staff were positioned along the corridor to allow for observation of patients and to ensure patient safety. Informal patients and staff had a key fob to access the unit. On Acorn unit, the patients had a structured programme so were with staff for the majority of the day. At other times, the patients in the therapeutic community took on the role of keeping each other safe.

Spring Lodge was a step down unit that enabled the patient free access to the building. The unit was risk assessed and the patient had a member of staff from Acorn unit present at all times in line with CQC registration guidance for hospital staffing. Bedrooms on Kemp and Acorn units were personalised, had anti-ligature furniture and doors with en-suite bathroom facilities. All areas were clean and tidy. We spoke with domestic staff and saw evidence of completed cleaning audits.

Patients could access shared communal spaces such as lounges but there were a number of locked rooms on Kemp Unit. Patients were individually risk assessed for access to the beverage kitchen and laundry facilities and key fob access arranged. However, patient access to the dining room and rehabilitation kitchen was restricted and required a member of staff to unlock the door. Garden facilities were available; patients on Kemp unit were escorted or observed when using the garden because the space was not contained. Acorn unit had recently purchased a shed to allow patients to keep pets at the hospital.

Patients on both units had access to a quiet room referred to as the snug or chill out room. These rooms gave patients a safe place to go to calm down. On Kemp unit access to the 'snug' or quiet room was via two locked doors so staff were required to open both doors before the patient could enter. The room had padded walls and soft furnishings chosen by patients. Kemp patients could also access a newly opened sensory room with special lighting, music, and sensory objects. This was located next to the 'snug' and required staff to unlock the doors to grant access. We found the room cluttered with cardboard boxes during the inspection. Although both rooms were lockable, staff told us that the room was not used to seclude patients. On Acorn unit, the chill out room was located on the main corridor and patients could access it at will.

Both units were female only and had no seclusion facilities. Staff told us that patients were not secluded. Staff said that if patients became agitated they would use techniques such as distraction until the patient became calm.

There was an alarm system in place and staff carried personal alarms. Nurse call systems were available in patient bedrooms, corridors and in all communal areas of the building. Both units had fully equipped clinic rooms to allow staff to examine and treat patients. They were clean and had accessible resuscitation equipment in date and ligature cutters; emergency drugs were checked regularly and were in date. Medicines were stored securely and access was restricted to authorised staff. Controlled drugs

were stored safely in a dedicated controlled drugs cupboard. Weekly stock checks had not been completed in line with the hospital's medicines code. On Kemp unit there was no system in place to ensure staff had completed up to date medicines training or that they had read and understood the hospital's medicines code.

Safe staffing

The Retreat York submitted nursing establishment whole time equivalents on Kemp unit between 1 June 2016 and 30 August 2016 as:

- Qualified nurse whole time equivalents: 12
- Support worker whole time equivalents: 20
- Number of vacancies – qualified nurse whole time equivalents: 3 average
- Number of vacancies – support worker whole time equivalents: 2 average
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 45
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 302
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 36

Day time staffing was two qualified nurses and four support workers, night time staff was two qualified nurses and three support workers. We viewed twelve weeks rotas and found these did not always reflect the recommended staffing levels. Although there were additional staff disciplines on the unit such as psychologists and occupational therapists for individual and group work who offered support, patients and staff both felt more staff were needed. Kemp unit had recruited two new support staff and had two long term agency qualified nurses whose hours were included in the figures. The unit manager told us that Kemp unit had three contracted agency nurses that had been working on the unit since April 2016 in advance of the unit opening. Two had consistent shifts and had completed the full package of Kemp unit training. In August 2016 the unit contracted four agency support workers though only two of these had worked consistent shifts and completed the structured clinical management training and Kemp unit induction day. The overall staff sickness for the organisation was 3% between 1 September 2015 and 31 August 2016. The Retreat York provided us with staff sickness figures for the previous 12 weeks; both units had rates of 2%, well below the provider's target. The provider had submitted figures of staff that had left the organisation from 1 September 2015 to 31 August 2016. On Kemp unit six substantive staff had left between 1 September 2015 and 31 August 2016; this equated to 20%.

Staffing was described as an issue on Kemp unit by support staff, nursing staff and patients across the hospital. We requested details monitoring movement of staff to Kemp unit to cover shifts but this was not recorded by The Retreat York. We spoke with five staff members on Kemp unit. One member of staff said that the unit had been short staffed for every day for the previous two weeks. We reviewed rotas and saw that the unit was frequently below staffing levels as set by the provider. Kemp unit was opened in May 2016 and the unit manager confirmed there was a pending review of the nursing establishment. We observed and staff confirmed that a qualified nurse was present in communal areas of the unit at all times and that patients had regular time with their named nurse. Patients and staff said that no activities or leave was cancelled due to a lack of staff. However, during a tour of the Kemp unit we noted that the emotions group had been cancelled due to a staff member being on annual leave. We requested data from the provider regarding instances where section 17 leave had been cancelled in the past three months; they said there had been no instances. Staff told us that there was adequate medical cover day and night, and that a doctor could attend the unit quickly in an emergency. There was a duty doctor rota and the consultant psychiatrist on the unit explained that staff called for advice when needed.

Kemp unit followed the mandatory training as set by the provider. Average training compliance was 80% which met the provider target of 80%.

The following courses did not meet the compliance target:

- Mental Capacity Act: 77%
- Child Protection Core Level 3: 73%
- Prevention and management of violence and aggression Level 3: 72%
- Food Hygiene: 71%
- Medicines Management: 70%
- Immediate Life Support: 67%
- Child Protection Level 1 Basic Awareness: 65%
- The Importance of Good Clinical Record Keeping: 61%
- Record Keeping Standards for Hospital Inpatients: 58%
- Prevention and management of violence and aggression Level 2: 0%

Tier 3 personality disorder services

Of the courses below target The Retreat York confirmed that prevention and management of violence and aggression level 2 is currently only assigned to staff as a reasonable adjustment when they are physically unable to do the full Prevention and management of violence and aggression course (Level 3). Level 3 prevention and management of violence and aggression is below the provider target at 72% and the provider was aware of this and addressing this issue by prioritising attendance at training.

We reviewed the figures for the training of bank staff as bank staff were used frequently on Kemp

The following courses were below the target:

- Face Care Partner - Basic Competency Training: 78%
- Fire Safety: 49%
- The Importance of Good Clinical Record Keeping: 30%
- Record Keeping Standards for Hospital Inpatients: 25%

Across the service, the lowest levels of mandatory training were in fire safety, prevention and management of aggression and violence level two, professional boundaries and record keeping. The provider told us that they were aware of lower compliance in these areas and was sending reminders to staff to complete these courses as well as reviewing staff training in prevention and management of aggression and violence level two.

During the inspection, we did not see an impact on direct patient care with regard to the lower areas of training compliance.

Training figures for medicines management further evidence the lack of following the provider's policy and poor medicines management. Agency staff usage is high on Kemp unit and immediate life support figures are lower than expected; this could impact on patients if staff could not respond in an emergency. The Retreat York confirmed that they are currently running an audit of record keeping and have a plan in place to address quality issues.

The provider submitted nursing establishment whole time equivalents on Acorn unit between 1 June 2016 and 30 August 2016 was:

- Qualified nurse whole time equivalents: 9
- Support worker whole time equivalents: 6
- Number of vacancies – qualified nurse whole time equivalents: currently 0
- Number of vacancies – support worker whole time equivalents: currently 0
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 3
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 7
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 5

Day time staffing was two qualified nurses and four support workers, night time staff was one qualified nurse and two support workers. We viewed twelve weeks rotas and found these were frequently below the staffing establishment. Although there were additional staff disciplines on the unit such as psychologists and occupational therapists for individual and group work who offered support, patients and staff both felt more staff were needed. Spring Lodge had one support staff day and night and clinical oversight was provided by the lead occupational therapist. These staffing resources were included in the Acorn establishment. Total numbers of substantive staff between 1 September 2015 and 31 August 2016 was 15; three staff (20%) left during this period. Acorn unit have since recruited a further two members of staff. The overall staff sickness for the organisation was 3% between 1 September 2015 and 31 August 2016. The Retreat York provided staff sickness figures for the previous 12 weeks; Acorn unit had rates of 2%, well below the provider's average. The provider had submitted figures of staff that had left the organisation from 1 September 2015 and 31 August 2016.

We spoke with five members of staff on Acorn unit. They all felt staffing levels were safe and where bank or agency staff were used they were familiar with the patients and unit. One member of staff described the newly recruited occupational engagement role as helpful and was positive about patients arranging many of their own activities. Patients on the unit said that staff were always available and responded immediately if they were in the office. We observed and staff confirmed that a qualified nurse was present in communal areas of the unit at all times and that patients had regular time with their named nurse. Staff told us that there was adequate medical cover day and night, and that a doctor could attend the unit quickly in an emergency.

Acorn unit followed the mandatory training as set by The Retreat York. Average training compliance was 87% exceeding the provider target of 80%.

The following courses did not meet the internal compliance target:

- The Importance of Good Clinical Record Keeping: 79%
- Prevention and management of violence and aggression Level 3: 77%
- Basic Life Support: 75%
- Child Protection Level 1 Basic Awareness: 75%
- Prevention and management of violence and aggression Level 1: 75%
- Record Keeping Standards for Hospital Inpatients: 74%
- Professional Boundaries: 61%
- Prevention and management of violence and aggression Level 2: 50%

Of the courses below target, the provider confirmed that prevention and management of violence and aggression level 2 is currently only assigned to staff as a reasonable adjustment when they are physically unable to do the full prevention and management of violence and aggression course (Level 3). Level 3 prevention and management of violence and aggression was below the provider target at 77%. Professional Boundaries was an updated course rolled out at the end of 2015 and training figures were 61%.

Assessing and managing risk to patients and staff

The Retreat York reported no incidents of seclusion or long term segregation between 1 March 2016 and 31 August 2016. Kemp and Acorn units did not have seclusion facilities. There were no incidents involving patients on Acorn unit during this same period. Kemp unit reported 118 restraints on four patients; 18 of these were episodes of prone restraint (where a patient is restrained face down) and four resulted in rapid tranquilisation. The unit manager confirmed that none of the current patient group had been restrained in prone position; a number of the restraints related to a previous patient who was moved to a more appropriate placement. They told us that if rapid tranquilisation had to be used there would be regular observations to monitor the patient. Other staff described the use of verbal de-escalation to prevent aggression when it occurred.

On admission, staff completed a functional analysis of care environments risk assessment for the patient. The functional analysis of care environments risk profile was included in the Department of Health's published guidance 'Best Practice in Managing Risk' (March 2009). Staff completed a further risk assessment every three months unless the individual patient circumstance means more are required as per the provider policy.

We viewed 14 risk assessments for patients. Risk assessments were completed in advance of the patients being admitted with the exception of three patients. One patient on Kemp unit had their risk assessment completed 18 days after being admitted to the service and although there was a detailed risk history, dates were not consistently documented. Another Kemp unit patient's was completed two days after admission and one Acorn unit patient's was completed 12 days after admission. The provider policy states that patients should have a completed risk assessment within eight hours of admission. We also saw that risk assessments were reviewed as a minimum three monthly and as when needed as per the provider's policy. Risk was also discussed in multidisciplinary team meetings, formulation meetings and handovers should an incident occur and review of risk be required.

Patients on Acorn unit were able to leave the unit at will as they were held informally and had the right to leave the unit if they wanted.

However, on Kemp unit, we found access to the snug, and sensory rooms were key locked and all patients had to have a member of staff unlock the doors. Access to the outside was also limited as the garden area wasn't contained and considered safe for some patients to access unattended.

Acorn unit did not use routine observations on patients but all patients had risk assessments completed. Patients were encouraged to hold emergency meetings to seek advice from the therapeutic community when they felt at risk of harming themselves or others. One patient told us of an emergency meeting she had called during our inspection. Kemp unit used zonal observations and placement of staff to cover blind spots. Kemp unit also had a more detailed local standard operating process for observations for staff to follow. Staff completed an observations form when handing over to another staff member. Patient searches were conducted on Kemp unit only. The unit manager

explained that they do not routinely search patients and only did so if the patient was considered to be at risk of harm to themselves or others; any searches conducted were explained to patients.

Any restraint used was reported via the incident reporting system and reviewed by the multidisciplinary team with care plans and risk assessments being changed to accommodate this. The units worked within the provider restraint policy and worked towards the least restraint. One care and treatment record asked staff not to use leg holds or prone position and another patient specified their preference of prone position.

We reviewed medicines management practice on both units. Medicines reconciliation was completed for all new admissions by the technician led service. Staff described a good working relationship with the pharmacy and patients were able to speak directly with a pharmacist if required. Medicines code and rapid tranquilisation policies were reviewed annually by the designated pharmacist. The pharmacy received, actioned, and disseminated medicines alerts and recalls and this was appropriately managed. Medicines incidents were broken down into core areas and were analysed by the pharmacy department. All incidents were reviewed in the clinical governance group as a standard agenda item and a pharmacist attended these meetings. Learning from incidents was shared at meetings and we saw how controlled drugs incidents had prompted a training package being developed.

On both units, the medicines were stored securely and access was restricted to authorised staff. However, medicines reviews were not documented and completed in line the hospital policy. On Kemp unit we reviewed five patient prescription charts. One patient had been prescribed a hypnotic medicine as and when required, which had been administered for more than seven days without a clinical review. As and when required reviews had been documented for one of the five records we looked at. However, this had not occurred on a weekly basis as per hospital medicines code. Nursing staff administration signatures did not always correspond with the prescribed medicines instructions. For example records showed one person had self-administered an antibiotic for three days longer than the prescribed course length indicating staff were signing without checking which medicines the patient had taken. A second nurse had retrospectively signed for a different member of staff on the medicines administration record which is not in accordance with Nursing and Midwifery Council guidance. We brought this to the attention of the hospital and an action plan was put in place to address these concerns.

On Acorn unit we reviewed five patient prescription charts. We found all charts were signed and dated and were in good order. However, we did not find evidence of staff completing reviews of as and when medicines. As and when medicines are medicines that are taken 'as needed'. If several medicines are taken together then there could be a resulting overdose.

Staff were trained in safeguarding and most knew how and when to make a safeguarding alert. Substantive staff described when to raise a safeguarding alert. However, agency staff on Kemp unit were unclear on the process and told us they would alert the manager or nurse in charge. Staff on the units told us that the provider's threshold was lower than the local authority. There were good links with the local authority, confirmed by the local authority, and staff and care and treatment records reflected safeguarding concerns. An allied health professional on Acorn unit told us they would raise a safeguarding alert on behalf of a patient if it was in their best interests. On Kemp unit 97% of staff had completed the Safeguarding Adults General Awareness, and 73% had completed Child Protection Core Level 3 training.

On Acorn unit, all staff had completed Safeguarding Adults General Awareness, and 91% of staff had completed Child Protection Core Level 3 training. The Retreat York had a children's visiting area available in a shared area in the main building which could be used should relatives bring children to visit patients.

Track record on safety

The provider reported that there had been nine serious incidents requiring investigation between 3 September 2015 and 5 August 2016. Of these seven related to Kemp unit and two to Acorn unit. Self harm was the main reason for the incidents and all were reported to the CQC at the time. Kemp unit had six instances of self harm and Acorn had two. Kemp unit also had one serious incident relating to inappropriate behaviour by an agency staff member. The hospital reported this to the agency, investigations were conducted and disciplinary action taken and support was given to the patient and the local authority informed. We viewed care and treatment records and could see that

thorough investigations had been completed. The unit manager on Kemp unit told us of a recent incident where a patient absconded which was managed in line with the provider's policy and patient's care and treatment plan.

We asked staff if they felt confident raising issues and concerns about care and practice with unit management teams. All staff, including bank and agency staff, said they felt comfortable raising issues with the nurse in charge or unit manager.

Reporting incidents and learning from when things go wrong

We asked staff if they knew what incidents to report and how. Staff on Kemp unit said they mostly reported incidents of self harm. Unit managers told us that all staff had access to the reporting system and notified the provider's safeguarding team. Staff told us that the person who witnesses the incident completes the form or the nurse in charge. The incident reporting form automatically updated the managers and leads at the Retreat York. Incident reporting forms incorporated a duty of candour section and staff were aware of the provider's policy and their responsibilities within this requirement. Unit managers took all incident reports to the morning managers meeting for review and discussion, which allowed them to obtain advice and support from other managers. Staff on both units were open and honest and could describe their responsibilities under the duty of candour when things went wrong.

The unit manager on Acorn unit told us that incidents were discussed in morning community meetings and, with the patients input, they looked at what could be improved. Staff told us that feedback was received at daily report out team meetings or emails and that 30 minute daily debriefs were held after their shift. The consultant psychiatrist from Kemp unit told us that the unit had created an individualised patient information sheet to share key information with agency staff to prevent incidents occurring. One agency member of staff on Kemp unit was not aware of the incident reporting system.

Are tier 3 personality disorder services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

We reviewed 14 care and treatment records which were held on the provider's electronic system. The files were secured by a password and only accessible by staff. Agency and bank staff has user accounts and were able to update the system. All patients had a comprehensive assessment after admission. However, we found that one patient's assessment on Kemp unit was completed 16 days after admission and one patient's assessment on Acorn unit was completed 19 days after admission. We saw regular reviews of the care plans on file. All records showed evidence of physical heath checks being completed on admission to the units and ongoing reviews of blood results being completed by staff. One patient on Kemp unit had detailed weekly physical health checks using the early warning score guide including weight checks, nutrition risk screening, blood pressure and temperature. We saw that flu vaccinations were also facilitated by the provider.

Patient care and treatment plans were mostly personalised and holistic; we saw that they reflected patient preferences and promoted independence, including when in crisis. We saw evidence that care and treatment plans identified individual support strategies and areas for skills development. With the exception of one record on each unit, all plans were written in the patient's voice. One care and treatment record on Kemp unit was incomplete and had a status of open. We found only one example of the service users preferences in their treatment plan. The patient had been admitted to the service three months prior to our inspection.

A local GP and practice nurses attended the units regularly to conduct patient health checks. They did not have access to the electronic recording system; consequently a paper record was kept in a separate file. Staff told us that scanning the notes of other professionals onto the system was historically completed by the unit clerks. However, since a restructure of the administration staffing it had now become the duty of staff on the unit. We were told and observed that daily blood tests could sit for several days before bring recorded on the system.

Best practice in treatment and care

The consultant psychiatrist on Kemp unit told us that the unit followed international guidance based on an absence of dissociative identity disorder National Institute for Health and Care Excellence guidance. The medical director for the provider said that there was no clear evidence base for patients with dissociative identity disorder. Kemp unit's

structured clinical management group used practices from 'Borderline Personality Disorder - An evidence-based guide for generalist mental health professionals' written by Anthony W. Bateman and Roy Krawitz in 2013. We did see that one Kemp unit care and treatment record referred to National Institute for Health and Care clinical guidance CG78 'Borderline personality disorder: recognition and management'. Kemp unit engaged with patients' multiple states and care planned for each whereas the Acorn unit patients learned to co-exist with their different states. There was no transition model for patients moving along the pathway from Kemp to Acorn units and this differing approach had not been resolved at the time of our inspection but we saw that both units had set an objective of establishing the pathway for the coming year.

Acorn unit followed a therapeutic community model where patients shared their daily life with others on the unit; patients took responsibility for sharing decisions about their lives. Both units had structured group work followed a dialectical behavioural therapy model. Dialectical behavioural therapy helps patients to change unhelpful behaviours; it places particular importance on the relationship between the patient and the therapist to actively motivate the patient to change. Patients also accessed psychotherapy such as cognitive behavioural therapy. Patients on Kemp unit also accessed interpersonal therapies and compassion focused therapy to help manage relationships. Both units had access to the psychology team that consisted of both psychologist and assistant psychologists. There had been a recent restructure of the psychology team that meant they now worked across the provider, instead of with a specific service or unit.

The service had good access to physical healthcare. For one patient who had repeatedly self harmed, the provider had worked with the local acute health trust to create an agreement plan for the patients' care when they attended for treatment. A general practitioner and practice nurse also visited the units twice a week.

Staff used health of the nation outcome scales to assess and record severity and outcomes, the Waterlow score to estimate risk of the patient developing pressure sores and the recovery star was also used on Kemp unit to measure patient outcomes.

Patients had access to food, drinks and snacks throughout the day and we saw that staff offered patients a choice of meals on both units. However, on Kemp unit we also saw staff completing meal choices on behalf of the patients who were in a community meeting. This meant that patients were denied the opportunity to make the decision or express their preferences.

Unit managers told us that staff completed audits on each unit including weekly audits of lithium medication. Kemp and Acorn units audited medicines charts, reviewed dates, storage and labels as well as fridge and room temperatures. Both units also audited record keeping and Acorn unit conducted an audit on care of patients with borderline personality disorder against national guidance.

Skilled staff to deliver care

The service worked as a multidisciplinary team that included nurses, support workers, psychiatrists, psychologists, cognitive behavioural therapists, art therapists, dieticians, occupational therapists, advocates, involvement worker, pharmacists, physiotherapists, and social workers.

Staff did not meet the services mandatory training compliance targets. Mandatory training was above 75% on all but two courses on Acorn unit and eight courses on Kemp unit.

The Retreat York submitted appraisal data prior to the inspection. On Kemp unit 11% of non-medical staff had received an appraisal since opening in May 2016. The provider told us that a number of staff on the unit were still within their six month probationary period. Taking into account these figures 40% of staff had received their appraisal. On Acorn unit 73% of non-medical staff had received an appraisal for the period 1 September 2015 to 31 August 2016. Doctors on the units had been revalidated. An effective appraisal system improves performance and patient outcomes and we saw evidence that appraisals were not a priority. When this is not in place, staff are unable to reflect on good or poor practice, set goals, and discuss training and development needs. This also reduces opportunity for managers to share lessons learned and good practice with staff.

There was an induction programme for all staff which included e-Learning and face to face training; support worker training also covered aspects of the support worker care certificate. There was an organisational induction and a local induction carried out on the units. We spoke with one agency member of staff on Kemp unit who told us that they had received no induction or unit orientation; another

told us that they had been given no specific training before starting on the unit. We viewed the induction schedule and orientation to the units. Substantive and bank staff on both units told us they had received an induction. Staff from other units explained that they were used to cover gaps in establishment on Kemp unit and they did not feel they had an appropriate induction to the unit or client group. Kemp unit had introduced a training program for agency staff prior to them starting to make them aware of the patients' needs.

The Retreat York had a supervision policy that stated that qualified staff should have nine supervision sessions per year. On Kemp unit, data provided showed that six staff had received supervision once since the unit opened in May 2016, and although two staff were not in post until October 2016, a further three had not received supervision since being in post from May 2016.

This is particularly concerning as Kemp unit is a new unit that has issues recruiting and retaining permanent staff.

Nursing staff on Acorn unit told us they had management supervision with the unit manager and additional clinical supervision every four weeks. They also described accessing a 'supervision and sensitivity' group on Mondays as needed. Acorn unit averaged five sessions per qualified staff for the period January 2016 to November 2016. Data submitted by Acorn unit showed consistent attendance for monthly supervision until May 2016; seven qualified staff received monthly supervision. This figure had decreased to three or four in the following months. One nurse had not received any supervision since June 2016. Support workers were also recorded as having monthly supervision on Acorn unit prior to June.

Staff told us that they had access to additional specialist training suitable to their role. Qualified staff received dialectical behaviour therapy training. In addition to this all staff also received knowledge and understanding framework training and living learning experience training. This involved the staff from Acorn unit living on Kemp unit for three days as a way of promoting reflective practice, enabling environments and emotionally safe working practices. The key goal of the knowledge and understanding framework training was to improve patient experience through developing the capabilities, skills and knowledge of the multi-agency workforces in health, social care and criminal justice who are dealing with the challenges of personality disorder.

Staff on both units said that training was mainly internal, but that it was accessible and flexible. One member of staff told us that they were scheduled for external dialectical behaviour therapy training in 2017. Staff on Kemp unit described how they had received two days structured clinical management training delivered by an external consultant psychiatrist and academic. The also attended dissociative identity disorder training and training in motivational interviewing, compassion focused therapy, inter-personal therapy and eye movement desensitization and reprogramming. However, not all staff on Kemp unit had received this training.

We saw evidence that staff performance was monitored at unit level and that concerning performance or incidents were investigated and managed by the senior leadership team. One staff member had received a final written warning in the last twelve months

Multidisciplinary and inter-agency team work

Personality disorder services had regular and effective multidisciplinary meetings. Kemp unit held daily report out meetings at the beginning of the shift for all of the multidisciplinary team; all patients and their risks were discussed. We observed one report out meeting and saw that all patients were discussed. In addition to this, handovers occurred three times a day at the beginning of each shift on both units. We attended a group meeting on Acorn unit where patients described how the previous 24 hours had been and presented a behavioural analysis. After the meeting staff from Acorn unit met to discuss any issues that had arisen. There was also an additional two hour meeting every Thursday where patients were reviewed in depth. One psychologist described how they attended the multidisciplinary meetings, supported with formulation and offered psychological interventions when required. The psychology team also supported the units with behaviour management plans and identified and managed triggers to behaviour. Allied health professionals on the unit attended review case management meetings weekly. Staff on Acorn unit described the multidisciplinary team as close and supportive. Two staff members raised a concern regarding the recent centralising of occupational therapists, psychologists and administration staff. They felt that the model was dependent on the allied health professional's knowledge about the patients on the unit and this would be lost in the new centralised services. In

terms of administration, unit staff now had to email a centralised administration pool to request services, adding to the unit's workload, instead of having an allocated clerk on the unit.

We found effective links with other organisations in terms of discharge planning. Staff described that involvement from external organisations could be difficult as patients were admitted from all over the country. The unit manager on Kemp unit explained that where possible community care coordinators attended care programme approach meetings and described the current patient group demographic. We reviewed 14 care and treatment records and saw there was evidence of discharge planning in nine of the records. We also saw details from care programme approach meetings and reference to difficulties of liaising with a home treatment team on Acorn unit. We found that the provider's social worker team were highly involved and patients had good links with local social services, particularly in terms of safeguarding.

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

On Kemp unit 82% of staff and 100% of staff on Acorn unit had received training in the Mental Health Act; this was part of their mandatory training and was scheduled to be refreshed every three years.

Staff in these wards confirmed that training had been completed in line with the Code of Practice, 2015. Staff explained the role of the Mental Health Act advisor in The Retreat York and knew how to make contact for any support. The Mental Health Act office examined all paperwork on admission. Staff told us that consent to treatment forms were attached to medication charts when required. We reviewed 14 care and treatment records and saw evidence of capacity to consent to medication and certificates of second opinions being recorded. We saw evidence of patients having tribunals and notes of these in the care records. Section 17 leave information was recorded on paper files and was struck through appropriately. Detention paperwork was stored with the Mental Health Act office and staff had access to an electronic copy. The manager of the Kemp unit told us that that if a patient wanted to leave the unit, and it was unsafe, they would attempt to discuss with the patient but would use the nurses holding power (section 5.4) within the Mental Health Act as a last resort.

Informal patients received a leaflet regarding their rights and conversations with patients were led by nursing staff. Staff explained patients' rights under the Act to them on a regular basis, and most patients were supported by an independent mental health advocate via a local advocacy service. The advocates are trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the Act and participate in decisions about their care and treatment. We observed posters on the units with contact details for the advocacy service but these were not included in the welcome pack. Patients' families were involved in their care, when agreed by the patient, and their contact details clearly documented on care records.

The Mental Health Act advisor produced twice yearly bulletins that were emailed to staff to update any changes in policy or law. The Mental Health Act advisor had comprehensive monthly audits in place for use of urgent treatment, holding powers and temporary holds on informal patients. The provider's audit manager conducted additional audits including ensuring information was given to detained patients, leave of absence from hospital and consent to treatment.

Good practice in applying the Mental Capacity Act

On Acorn unit 94% of staff, and 77% of staff on Kemp unit, had received mandatory training in the Mental Capacity Act. The provider had a Mental Capacity Act and Deprivation of Liberty Safeguards policy available on the provider's shared network for staff to refer to. Staff explained that they contacted Mental Health Act advisor in The Retreat York for any support. Staff were seen to have a good understanding of Mental Capacity Act 2005 and were aware of the five statutory principles. Staff on Acorn unit said that the Mental Capacity Act was not often used as patients were informal and had capacity.

On Kemp unit the unit manager said that specific capacity assessments were not routinely completed and that patients may lack capacity dependent on which dissociative state was presenting. We did not see best interest decisions for patients where their disassociated state may lack capacity. Other staff we spoke with on the units confirmed that capacity was assumed unless there was a reason to suggest otherwise.

There were no incidents of restraint recorded on Acorn unit between 1 March 2016 and 31 August 2016; Kemp unit

recorded 118 incidents. We saw evidence in care and treatment records that patients were restrained as a last resort, for the shortest time possible and only after all other steps to manage a crisis had been used. A psychologist on the unit described how they worked with the patients after incidents to identify alternative future strategies.

Adherence to the Mental Capacity Act within the hospital was monitored via the audit lead at the Retreat York.

Are tier 3 personality disorder services caring?

Kindness, dignity, respect and support

We observed staff to be kind and caring towards patients on all units. Staff were warm and interacted thoughtfully with patients. On Kemp unit staff interacted with the different dissociated states of patients that were presenting as per Kemp's model of care.

We spoke with seven patients during the inspection. Patients told us that staff saw them as people and not as a condition. Patients said they felt safe on the units. Patients felt comfortable with regular staff, one patient described an occasion where they had challenged a staff member for arriving late to their appointments. The staff member completed a behaviour analysis record at the request of the patient and it was discussed in the morning community meeting. Patients on Kemp unit explained their discomfort with agency staff and unease with male staff members on night shift. Another patient on Kemp unit said that staff were interested in the patient's wellbeing and that they were the best staff that they had ever experienced.

We received six comments cards in relation to personality disorder services; two for Acorn unit and four for Kemp unit. Patients on Acorn unit described the service as collaborative and said that they were involved in their care. However, they also felt that there wasn't enough security in place at night. We asked the provider about the arrangements in place for security at night. Each unit had an electronic door system to gain access to the units, meaning a swipe card or a member of staff granting access was required. They also told us that unit doors were locked at night as per their policy. Kemp unit comments related to agency staff usage and one agency staff said that permanent staff didn't involve them. Patients on the units also commented that the unit was amazing, safe and clean.

The involvement of people in the care they receive

We saw that all patients received a patient information pack which contained useful information including: a description of the service model, the philosophy of the unit, compulsory groups with timetable, details of the roles of the multidisciplinary team, smoking arrangements, contact with families and friends and information on how to make a complaint. Patients also received a leaflet that described what to expect in the first 48 hours of admission to the units. This included photographs of staff and the units and described the facilities and admission process. A schedule for the day was also included. Patients confirmed that they had received an orientation to the unit.

Patients accessed advocacy through a local service and patients were actively involved in staff recruitment and decisions which affected the service; patients had presented formally to the board about how it felt to be a patient. Patients had daily meetings where they could feedback on the units.

Patients on Acorn unit had been given an allowance to go shopping for accessories to decorate the communal spaces. Patients also told us of their enjoyment of the pets corner where they cared for the providers and their own pets on site. Acorn unit had recently purchased a shed and were in the process of arranging heating to allow patients to keep their pets on the unit. Acorn patients also described their enjoyment of free time at the weekend and told us of activities and clubs that they participated in. One patient on Kemp unit explained that they felt their access to technology was overly restricted.

We asked the service for contact details for carers and family members to seek additional feedback. However, no families or carers on these units wished to speak with us. There were no carers or families that we saw visiting during our inspection. We viewed minutes from the quarterly carers focus group held by the involvement lead at The Retreat York. They described a lack of communication with carers, and some were unclear about their family member's recovery pathway and key contacts. We noted that some actions from the meeting had been completed and there was now a carer information board on the units. Patients confirmed that families were involved in their care if they wished and we saw contact details in patient care and treatment records.

Tier 3 personality disorder services

We reviewed 14 care and treatment records for patients. Although we found some care plans to be generic and written about patients, we also saw individual preferences were included, goals written by the patients, details of what was important to them; one record did not have a respect my wishes document and it was unclear as to whether the patient had declined to complete the form. Care and treatment records were signed as agreed to by the patients and they confirmed they received a copy if they wished. Care and treatment records also showed family involvement; family members attending care programme approach meetings; discussions with family members about the future and families being referred to the family and carers forum. Care and treatment records also recorded if families were not to be involved as per patient wishes.

Are tier 3 personality disorder services responsive to people's needs?
(for example, to feedback?)

Access and discharge

The average bed occupancy of Acorn unit for the period between 1 March 2016 and 31 August 2016 was 60%. Kemp unit had opened in May 2016 and The Retreat York reported bed occupancy until 31 August 2016 as 47%. When patients went on leave they were able to return to their rooms. We saw that care and treatment records referred to aftercare services where appropriate.

The provider reported that neither unit had any delayed discharges. Both unit managers told us that they were able to, and had in the past, refused new admissions to the unit as the patient mix was not suitable. Patients were admitted and met with the GP and consultant psychiatrist on Mondays. Patients were also discharged or moved at an appropriate time of the day. The unit manger on Kemp unit told us that the unit had reflected on learning from the last discharge of a patient to an alternative hospital and how they tried to identify why the patient didn't engage in the programme to prevent it from reoccurring at The Retreat York in the future. The provider explained that when a patient required a transfer to a psychiatric intensive care unit or acute mental health environment, they liaised with the patient's home team care coordinator and local crisis home treatment team. They confirmed that delays can occur as local Trusts cannot identify a bed immediately due to national shortages.

The facilities promote recovery, comfort, dignity and confidentiality

Both units had a full range of rooms available including clinic room, therapy rooms, lounges and activity rooms. Kemp unit had a sensory room and 'snug'; Acorn patients had access to a chill out room. The units also had a room where patients could meet with visitors.

Patient belongings could be secured in a locked drawer in their rooms and there was also a locker for restricted items such as hair straighteners, where patients had been risk assessed as being unable to store items in their rooms. We saw that patients had personalised their bedrooms and patients on Acorn unit had also been shopping and chosen ornaments to display along the main corridor. Both units had a brew up kitchen with access to hot drinks and snacks 24 hours a day. Patients on the Kemp unit were individually risk assessed and were given access via key fobs if appropriate. Those on Acorn unit had access at all times.

Acorn unit had an enclosed garden and patients were free to use it when they wished. Kemp unit had access to a garden but patients on one to one observations were unable to access the garden without being in view of staff as the garden was not enclosed. Patients also told us that they went off site regularly on leave, escorted by staff where appropriate.

Patients had access to personal mobile phones and could make calls in private in their rooms. One patient on Kemp unit had restricted access due to safeguarding concerns. We reviewed the patient's phone use care plan which stated that all calls on the patient's mobile phone were to be supervised and limited to between the hours of 08:00 and 20:00. The patient was able to use the unit mobile phone until 22:00 to call family members and the police if required. The patient was also unable to send text messages or use the internet without supervision. We asked the patient's named nurse what would happen if the patient wanted to make a call in private and they said they would seek advice from the nurse in charge and unit manager. Neither the patient's solicitor nor the CQC were on the list that the patient was allowed to contact. The patient's phone use care plan said that the patient had

seen the plan and was in agreement with it but we saw no signature recorded. We saw that the social work team had met and discussed the phone restrictions with the patient but saw that there was a lack of patient involvement in the reviews. We also reviewed that patient's care and treatment plan and saw that it had not been updated to reflect the phone plan.

Spring Lodge, although registered with the CQC as a hospital was more in keeping with a personal dwelling; the patient was able to cook meals, attend outpatient activities and come and go as they wished.

Patients told us the food was good quality but was served at set times. Patients described the food as better than hospital food and confirmed that they had a choice of meals. Patients on Acorn unit enjoyed self-catering at the weekend and eating out.

On Acorn unit there was a timetable of activities Monday to Friday including; morning and evening community meetings, dialectical behaviour therapy skills training groups, 'out of session' work groups, therapy consultation groups, weekly group psychotherapy, life skills group, art therapy group, meal times and post meal support group, assessment groups and night rounds. There were no therapy groups at the weekend with the exception of the post meal support group and evening community meetings.

Kemp unit activities were delivered on the unit in group and in one to one coaching formats as appropriate. Activities included dialectical behaviour therapy skills training groups, emotion regulation and management, cognitive behavioural therapy relation specifically to fear, anxiety, anger and sadness. Activities also included borderline personality interpersonal skills, understanding and coping with dissociation, ego strengthening resources and coaching compassion focused therapy group art and creative therapies including movement, drama and music.

Arts and crafts, board games and puzzles were also available on both units. There were also optional groups on both units such as going swimming, yoga, scrapbook group and Friday fun. Patients enjoyed going to pet's corner where they kept and looked after a variety of animals on The Retreat York site and accessed animal therapy via a local charity on a monthly basis.

Meeting the needs of all people who use the service

Both units were on the ground floor and patients who had mobility issues and required equipment to assist them could access the units.

The onsite catering facilities and staff were able to meet dietary requirement needs of any religious or ethnic background. The lead chef at The Retreat York described how halal and kosher meals were prepared in a different manner for patients with different religious beliefs and that there was always a vegetarian option available. The dietician worked closely with the catering team. On Saturdays patients were offered a cooked breakfast and Sundays and holidays were marked with traditional lunches. Patients were able to meet with the catering team and 20 patients attended the last 'meet the chef event'. The chef told us that a third of the new menu were patient's choices, some were traditional favourites and the chef's introduce new dishes for the patients to try on a regular basis.

There was access to a range of spiritual and faith support facilitated by the chaplain who was on site two and a half days a week. The chaplain worked with patients on Acorn unit and held mindfulness sessions for the patients. The chaplain incorporated different patient's faiths into services. The provider had a quiet room available for patients spiritual needs; it was intentionally not referred to as a prayer room as the room was available to all. We viewed a leaflet for patients that offered information and support for spiritual health at the Retreat York. The chaplain told us that the provider runs an 'S-group'; collectively the patients and staff look at the organisation's approach to spirituality. Patients and staff spoke very highly of the chaplain and explained the support that the chaplain offered. The provider also arranged access to local churches for those patients who wished to attend services.

Information leaflets were available but we did not see leaflets in different languages. However, staff told us these were available if required by a patient. In order to communicate with non-English speaking patients The provider accessed a translator service via the telephone.

Listening to and learning from concerns and complaints

Tier 3 personality disorder services

Patients confirmed they knew how to complain and details of the complaints process was in the unit information pack, leaflets and feedback books that we viewed on the unit. The Retreat York's complaints policy accepted concerns via verbal, written or electronic means.

There were two complaints in the last 12 months on Acorn unit; both complaints were partially upheld and neither was referred to the ombudsman. One issue related to a lack of a response to a complaint raised and wording of a letter that a patient had received. The second complaint was in respect to the closure of the courtyard and the installation of anti-ligature toilets. The provider acknowledged that improvements in communication could be made. No complaints had been received for Acorn unit since October 2015. No complaints were logged for Kemp unit or Spring Lodge since opening in 2016. Patients on Kemp unit could enter any concerns they had in a concerns log in the lounge. The unit manager described concerns raised regarding the use of agency nurses. The service responded immediately at a business meeting and subsequently employed agency staff on contracts. The service and the patients collaboratively created a one page profile for each patient to share with agency staff. Staff told us that complaints were fed back at staff meetings and community meetings, but did not refer to a formalised process.

We reviewed five complaints from across the organisation during our inspection. We found the complaints process to be clearly defined with distinct timescales; the chief executive of the organisation signed all complaints. However the recording of verbal complaints on the units was less clear. Patients would have to telephone the risk department, who triaged complaints, rather than unit staff recording the details. We also found limited evidence that people were supported to complain; Although we saw a complaints leaflet that said patient care would not be affected as a result of a complaint, we saw no further evidence in the complaints records reminding patients or families of this. It was not clear that people were offered the choice to keep their complaints anonymous or that all investigators had been trained in root cause analysis. Learning was fed back to staff via the Retreat York's sharing and learning bulletin and quarterly reports.

Are tier 3 personality disorder services well-led?

Vision and values

All staff spoken to understood the vision and values of the provider. One support worker had suggested and led a two week programme emphasising the provider's values in the month prior to our inspection. This programme was received well by patients and staff and values were observed to be demonstrated. The values of The Retreat York are:

- Equality and community
- Hope
- Care for our environment
- Peace
- Honesty and integrity, and
- Courage

We could not find specific evidence detailing how individual team objectives reflected the organisations objectives. However, the values were embedded on the units and were incorporated into the ethos of the unit.

All staff spoken with knew who the senior managers were within the organisation and confirmed they were visible on the unit. The new chief executive had visited and worked shifts alongside domestic and nursing staff as part of their induction to the service.

Good governance

The Retreat York had a training manager who recorded and scheduled mandatory training for each unit. Training figures for medicines management were below 75% and we found medicine's management to be lacking on Kemp unit; medicines reviews were not documented and completed in line with the hospital policy. Additional training was arranged or delivered by staff on the unit, however recording of additional training was not centralised. We asked the provider for details of additional training for all units including personality disorder services and the unit managers provided details of courses. Staff spoken with agreed that they had access to additional internal and external training. Mandatory training figures on Kemp unit were lower than the internal target.

Although the service monitored appraisals and supervision attendance, it was not consistent. Supervision and

appraisal were not taking place as per the provider's own policy. Acorn unit's supervision rates dropped in June 2016 which coincided with Kemp unit opening. Appraisal rates were also low at 40% although the provider told us that the end date for appraisals was January 2017. Since the unit opened in May 2016 three staff had not received supervision and a further six had only received it once. Although staff told us they felt supported we did not see evidence of this in supervision attendance records.

Staffing levels were set by the leadership team, according to NHS England guidance and were adjusted to incorporate patient observation levels. The unit managers and nursing staff confirmed that they had sufficient authority to increase levels when needed. Kemp Unit relied on agency staff and had offered temporary contracts to some agency staff. There was a clear escalation procedure and staffing levels were checked against the rotas for each shift. On Kemp unit 36 shifts had not been filled since opening in May. Patients may be placed at risk when staffing numbers do not meet the appropriate levels. There was a high number of restraints (118) recorded on Kemp unit but the service appeared to have settled since the arrival of the unit manager, the introduction of contracted agency staff and a patient whose needs could not be met by the service being moved to a more appropriate service.

Staff were undertaking some clinical audit on the units and the provider supported the units by undertaking overall audits of areas such as the Mental Health Act. The organisation was not taking part in national audits or peer review schemes which would support them to identify improvements in practice. Acorn unit had however been accredited by The Community of Communities Scheme for 13 years; current accreditation runs until June 2017.

Staff had good knowledge of safeguarding procedures, reporting procedures and knew how to identify abuse. Staff had been trained in and evidenced knowledge of the Mental Health Act and Mental Capacity Act. Staff were also able to submit items to the local and provider risk registers.

We saw evidence that both units were measuring team performance and reporting on a quarterly basis. Easy to read documents were displayed on notice boards on units and identified the number of complaints, audit results, incidents, medication errors and compliments per unit. They summarised outcomes and results.

Both units also had objectives that they were working towards. These were:

Kemp unit:

- The development of a pathway between the personality disorder services with Acorn unit
- Recruitment; recruit to a full complement of permanent staff and revise ways of recruiting
- Specialist training for all employees
- Review therapeutic activities timetable
- Environmental improvements, including; garden, lighting and potential redevelopment of unused bedrooms

Acorn unit:

- The development of a pathway between the personality disorder services with Kemp unit and Spring Lodge
- Improved reporting and sharing of outcomes
- Improved occupancy; including review of website and literature use
- Update staff therapeutic community core competencies to reflect Community of Communities (2014) competencies
- Development of a training matrix to reflect required training in line with job role and therapeutic community core competencies
- Review programme timetable

Unit managers and clinical staff told us they did not have access to sufficient admin support following a recent review of arrangements. However, unit managers did feel that they had sufficient authority to do their job.

Leadership, morale and staff engagement

The annual staff survey was completed in May 2016 but related to the provider as a whole rather than specialist personality disorder services. Key themes for action were:

- Communication
- Leadership
- Pay and benefits

The provider had an action plan in place to review the above themes in the hope of a more positive response to the staff survey in 2017.

Sickness and absence rates were below the organisations target of 3% on all units. There had been an issue with staff retention on the units. Kemp unit had six staff leavers since opening in May 2016 (20%) and Acorn unit had three staff leavers in the last twelve months (20%).

Staff from both units knew how to use the whistleblowing process and had raised concerns regarding the staffing levels on Kemp unit with the CQC since the unit had opened.

At a local level, staff told us that there was no bullying or harassment, they loved their jobs and felt lucky to work at the Retreat York. They described good working relationships with the unit managers and senior multidisciplinary staff. Staff felt able to input ideas for patient support as well as their own roles. Agency staff on Kemp unit told us that their opinions were listened to and they felt valued and accepted. They also praised the open and honest approach to teamwork that the unit had. Clinical leads were proud of the levels of compassion and empathy that staff had for patients.

Staff on Kemp unit told us that the multidisciplinary team had not been involved in the planning and opening of the unit. They told us that this had been facilitated by the unit consultant psychiatrist and director of operations.

Staff on Acorn unit told us they had felt anxious about the safety of their roles, targeted by the senior leadership team and that relationships had broken down with them. They told us that the culture was changing and described the new chief executive officer as refreshing. Staff acknowledged that they now felt able to raise concerns with the new chief executive officer without fear of victimisation. They confirmed that they had raised these issues with the new chief executive officer.

Teamwork was evident throughout the inspection when we spent time observing staff on all units. Staff supported each other and offered help to ensure the best outcome for patients. Staff told us that they felt supported by their colleagues and the wider multidisciplinary team. It was evident when observing staff with patients that they enjoyed their jobs and were compassionate towards the patients they were working with. Unit managers were supportive of their teams and passionate about how hard staff worked with patients. Unit staff described patients as a priority and spoke highly of the involvement office whose role was to make sure that patients' voices were heard.

Unit managers told us of opportunities for development and described leadership training led by an organisational development consultant.

Commitment to quality improvement and innovation

Acorn unit had been accredited by The Community of Communities for 13 years; current accreditation runs until June 2017. The Community of Communities is a quality improvement and accreditation programme for therapeutic communities in the UK and overseas. This accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided.

Acorn unit were actively involved in clinical research and invited to present at conferences. One of the clinical psychologists had published a clinical outcome article last year on the topic of borderline personality disorder: patterns of self-harm, reported childhood trauma and clinical outcome.

The ward manager on Kemp unit told us that they had not been accredited or involved in any improvement methodologies or schemes because the unit had opened in May 2016.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are offered regular appraisal in line with its own policy. Appraisal rates were low on the units and did not adhere to the provider's own policy.
- The provider must ensure that staff record the reason for missed medications on all unit.
- The provider must ensure symptoms are indicated to guide staff when and in what order to administer as needed medicines.
- The provider must ensure reasons for missed dose administration codes and actions taken are recorded appropriately.
- The provider must ensure medicines reviews are documented and completed in line the hospital policy.
- The provider must ensure that staff administration signatures always correspond with the prescribed medicines instructions.
- The provider must ensure that medication care plans are updated and contain information about the entirety of a patient's medication including dosages and patient preference for administration of medicines.
- The provider must ensure that covert medications are recorded when given covertly and that best interest decisions are recorded on patient records not only in multidisciplinary team meeting minutes.
- The provider must ensure that detailed body maps are completed for patients with a transdermal patch, to reduce risk of skin irritation.
- The provider must ensure that all medication is dated once opened to ensure staff are aware of its use by date.
- The provider must ensure that all patients have a timely review of their placements and that discharge processes are thorough and active to reduce delayed discharge and an overdependence on the service.

Action the provider SHOULD take to improve

- The provider should ensure that patients on the George Jepson unit are engaged in meaningful activity and that this is adequately monitored and recorded.
- The provider should ensure that an electrocardiograph machine can be accessed on each site.
- The provider should review restrictive practices such as locked doors and ensure these are assessed on an individual basis.
- The provider should ensure that all shifts meet the planned staffing establishment level to ensure patient safety.
- The provider should ensure that all staff are offered regular supervision in line with its own policy. Supervision rates were low on the units and did not adhere to the provider's own policy.
- The provider should review administrative and maintenance support to the units to ensure administrative tasks are undertaken in a timely manner where linked to patient care.
- The provider should ensure that training in all courses including fire safety, record keeping, professional boundaries and prevention and management of aggression and violence meet training compliance targets on all units.
- The provider should ensure that informal patients are made aware of how they can leave the units.
- The provider should ensure that patient risk assessments are updated on a regular basis.
- The provider should ensure that when patients refuse physical healthcare checks a care plan and risk assessment is in place to mitigate and reduce risk.
- The provider should ensure that all bank agency and staff covering shifts receive local inductions to units.
- The provider should ensure that there is an effective process to ensure learning from investigations into incidents and complaints.
- The provider should ensure that all staff have access to training specific to their role.
- The provider should ensure that there is sufficient space for all patients to access a seat in the dining room at mealtimes.
- The provider should ensure that people are supported if they wish to make a complaint.
- The provider should ensure that staff concerns relating to blame culture and victimisation continue to be monitored and ensure that action is taken to review and address progress.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that on older people's units: • The care and treatment of all service users was appropriate and met their individual needs. **How the regulation was not being met:** • Patients on older people's units had significantly long lengths of stay. On George Jepson unit the average was 6.8 years and on the Katherine Allen unit it was 6.1 years; For some patients, the placement was not appropriate. We did not see evidence that the provider had made every effort to support patients to move on from hospital to less restrictive settings. This was a breach of Regulation 9.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that: • Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review. • Staff must follow policies and procedures about managing medicines, including those related to infection control. **How the regulation was not being met:** George Jepson unit:

This section is primarily information for the provider

Requirement notices

- No reasons for missed dose codes were recorded or action taken to encourage administration or inform prescriber.
- The medicines electronic record in the daily notes did not always correspond to the codes documented on the medication administration record or provide details of outcome of administration or reasons why medicines had been refused.
- Care plans did not always provide detailed medicines information or cover all aspects of care. They were not always updated when changes had occurred.
- Medicines were covertly administered to some patients, best interest meetings were documented in records but reviews were not documented at the frequency stated on the care plans.
- Body maps were not consistently used to identify the locations where transdermal patches had been placed.

Kemp unit:

- Weekly stock checks had not been completed in line with the hospital's medicines code.
- No system was in place to ensure staff had completed up to date medicines training or that they had read and understood the hospital's medicines code.
- Medicines reviews were not documented and completed in line the hospital policy.
- As and when required reviews had not been documented as per hospital medicines code.
- Nursing staff administration signatures did not always correspond with the prescribed medicines instructions.

Naomi unit:

- Medicines related care plans did not always provide detailed information with regards to dosages or patient preference for administration.
- For 'when required' medicines symptoms were not always indicated to guide staff when to administer.

This section is primarily information for the provider

Requirement notices

- For patients with multiple medicines no written guidance was available as to which item was to be given first or when to administer the second item.
- Reasons for missed doses were not documented in narrative and any actions taken were not recorded.

This was a breach of Regulation 12(2)(g).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not ensure that all staff received appropriate support, professional development supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How the regulation was not being met:** Appraisal figures across the organisation were low: • On George Jepson unit 57.5% of non-medical staff had received an annual appraisal. • On Katherine Allen unit 65% of non-medical staff had received an appraisal. • On Naomi unit 59% of non-medical staff had received an appraisal. • On Acorn unit 73% of non-medical staff had received an appraisal. • On Kemp unit 40% of non-medical staff had received an appraisal. This was a breach of regulation 18 (2) (a).