The Retreat York

The Retreat - York

Inspection report

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Date of inspection visit:
07 June 2016

Date of publication:
02 July 2019

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**

Summary of findings

Overall summary

The focused inspection of The Retreat took place on 7 June 2016 and was unannounced. We carried out an announced comprehensive inspection of this location in October 2015, against the regulated activities 'Treatment of disease, disorder or injury', 'Assessment or medical treatment for persons detained under the Mental Health Act 1983' and ' Diagnostic and screening procedures'. After that inspection we received concerns in relation to; the use of prone restraints on two tenants, the registered provider's understanding of Mental Capacity Act 2005 (MCA) compliance, and emergency responses to incidents. These concerns related specifically to two supported living units at The Villa and The Cottage. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics and only in relation to the two supported living accommodation units. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Retreat - York on our website at www.cqc.org.uk

The Retreat is an independent specialist mental health care provider for up to 98 people with complex mental health needs. It also provides assessment or medical treatment for persons detained under the Mental Health Act 1983. The service is located on the outskirts of York. Since September 2015 The Retreat has also been registered for the regulated activity of 'personal care' to provide domiciliary care services to people renting their accommodation under supported living arrangements. This is also provided now on the site of the hospital location, in two units known as The Cottage and The Villa.

People that use this service are not detained under the Mental Health Act 1983 (MHA), and may have learning disabilities and autistic spectrum disorder. It is this regulated activity that sits more comfortably within Adult Social Care provision and so this directorate of CQC was involved in the focused inspection of the service. At the time of our focused inspection there were six people using the service: four females and one male at The Cottage and one male at The Villa.

The registered provider was required to have a registered manager in post. On the day of the inspection there was a manager that had been registered and in post for the last nine months with regard to 'personal care' and longer for the other regulated activities registered at the location. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. 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.

We found that people were not always protected from harm and abuse because although the registered provider had systems in place to protect people from abuse and staff were aware of their responsibilities to protect people, the registered provider was carrying out restraints and depriving people of their liberty without the proper authorisations in place under the Mental Capacity Act 2005 (MCA) and following authorisations by The Court of Protection.

Several areas of practice at The Cottage and The Villa were being inappropriately carried out: 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 equipment designed to reduce anxiousness for people with autism, such as wrist weights, hand held restraint for the purposes of providing personal care and people reliant on only two-to-one support to access the local community therefore under continuous supervision.

People that live in their own homes or in supported living accommodation can only be lawfully deprived of their liberty when following an order of the Court of Protection. Because people that used the service were not legally detained under the MHA and because the use of DoLS was not applicable to people living in their own homes we would expect that people unable to protect themselves from harm, for example, in the community, would only be subjected to restrictions on their liberty from orders made by the Court of Protection. These had not been applied for when we visited the service for all tenants.

This was a breach of regulation 13 (4) (b) and 13 (5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It was also in contravention of the requirement to have an order in place from the Court of Protection. You can see what action we asked the registered provider to take at the end of this inspection report.

We found that while there were sufficient staff on duty each shift to meet people's needs on a day-to-day basis there was a risk that, at times of emergency, insufficient staff were deployed to respond to the needs of people during those emergencies. This had been the case during one incident of restraint where all available staff had been deployed in the restraint and there was no staff member free to raise the alarm. There were alarms in place, however we found that these only linked between the two services, and not to the main Retreat site. This meant that summoning help was reliant on staff being able to access the land line. However, this was a failing of the registered provider's procedures and practice to manage incidents where people that used the service were at risk of injury or harm and not a concern about sufficient staffing on duty. It was also a failing to ensure that people's rights were protected. We made a recommendation to the registered provider about this to ensure staff followed robust procedures with regard to their deployment at times of emergency.

There were appropriate risk assessments in place to ensure people were not placed at risk, but at the beginning of the provision of the regulated activity 'personal care' there had been some careless omissions in identifying the risk that people presented and put themselves and others at, because of their behaviour.

The registered manager followed recruitment procedures to ensure staff were suitable to care for and support vulnerable adults and we found that staff had not been employed in the service until after their security checks and suitability to work had been cleared. However, we found that one staff member had started work before the provider had obtained their references from the previous employer.

There were appropriate and safe systems in place to manage medication and while some issues regarding medication concerns we saw had been highlighted in a May 2016 medication audit completed by a supplying pharmacist, the unit manager assured us these issues had been addressed and further changes were being considered to further improve on the systems used.

The registered provider had not always ensured that people's risks relating to their health, safety and welfare had been properly assessed, monitored and mitigated. There was evidence that the staff were not made fully aware of the needs of people that had moved to The Cottage and The Villa in the first few months of the units opening. People had therefore been at risk of harm due to the lack of information and

mitigation of risk.

While there was information in people's care files that evidenced the range of records held about people the registered provider had not always maintained complete and accurate records about, for example, people's past lives. There was information missing from some records and some documents were missing entirely from the files. We found that MCA assessments had not been fully completed, not all documents had been signed or dated and appropriate / relevant information was sometimes missing.

This was a breach of regulation 12 (1) (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the registered manager to take at the end of the inspection report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

While safeguarding systems were in place and used and staff were trained in safeguarding adults from abuse, people were not always being supported safely. This was because the culture of the service was one where it was deemed acceptable to use restraint for reasons other than as an ultimate prevention of, or a proportionate response to, harm to people and others.

Best interest process had not been consistently used to ensure people's rights were protected.

Staffing levels were sufficient to meet people's needs but staff were not always deployed appropriately to ensure people were kept safe. Recruitment procedures were robust and safe and the management of medicines was safely carried out.

Is the service effective?

Inadequate

The service was not effective.

People were cared for and supported by trained and qualified staff, that received appropriate supervision and took part in an appraisal scheme.

People's rights were not upheld in relation to their mental capacity, because some people moved to the service before best interests decisions had taken place. We found that people were subject to deprivations of liberty, but applications to the court of protection had not been made, and we could not find evidence that the provider was following this up.

The best interest route was not always followed and people were being restrained unnecessarily with the belief that written support plans were sufficient to enable restraint to take place.

The Retreat - York

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at safe care within the service, but not to provide a rating for the service under the Care Act 2014 as the inspection was a focussed inspection and not a comprehensive rated inspection.

The inspection of The Retreat took place on 7 June 2016 and was unannounced, although the registered manager told us during the inspection that they expected a visit from us following the submission of some safeguarding referrals they had recently made to York City Council. One Adult Social Care inspector and two Mental Health hospital inspectors carried out the inspection.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with The Retreat and reviewed information from people who had contacted CQC, since the last inspection, to make their views known about the service.

We spoke with two people that used the service, the registered manager and four staff that worked at The Retreat. We looked at care files belonging to three people that used the service and at recruitment files and training records for five staff. We looked at selected records and documentation relating to the running of the service, including medication management, safeguarding systems, risk management systems, accidents / incidents / restraints and staffing rosters.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

The Retreat had registered in September 2015 to provide the regulated activity of 'personal care' to people that moved into The Cottage and The Villa, two units at the location allocated as 'supported living' accommodation for people with learning disabilities. We established that the organisation was providing, under separate branches, both 'supported living' accommodation and domiciliary care services to people in the units and we were told by the unit manager that people could receive the domiciliary care service element from any agency of their choosing. This reduced the risk of there being an organisational conflict of interest with the arrangements, though no one had taken up the right to receive domiciliary care services from any other independent agency.

We discussed with the registered manager and unit manager whether or not the location had registered the regulated activity of 'personal care' correctly with regard to what The Retreat intended to provide and we asked our registration team if the service was appropriately registered to provide 'personal care'. The registered manager, unit manager and CQC registration team were satisfied that the regulated activity was correctly registered. People that lived in The Cottage and The Villa were tenants who received care and support in their own home from a domiciliary care agency established only to provide that type of service to people in the two units at the location.

People we spoke with told us they felt safe living at The Cottage and The Villa. People presented as satisfied with the arrangements for their support; they were jovial, smiling and interested in life. Four of them went out as a group with staff to attend an event at York Museum Gardens and took a picnic with them for lunch. On their return they told us they had enjoyed their day.

The service had systems in place to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how they would refer suspected or actual incidents to the local authority safeguarding team. There was evidence in staff training records that staff were trained in safeguarding adults from abuse. There were records held in respect of handling incidents and the safeguarding referrals that had been made. These corresponded with those we had been informed about by the service through formal notifications to us, which numbered three safeguarding referrals.

These referrals had been made in the first six months of the units being opened. However, the referrals and notifications to us could have been timelier. At the end of May 2016 the registered provider sent us a notification containing three incidents that had taken place in the units . The reason given by the registered manager and unit manager for the delay in making these referrals and the delay in notifying us was that staff had not informed the registered manager immediately after the incidents had occurred; the first one being in December 2015 and two others in April 2016.

One of the notifications we received was regarding a 20 minute restraint that took place when staff were unable to summon help because they had all been involved in the restraint. This was poor judgement and poor practice because the restraint ought not to have taken place in the first instance and it ought not to

have involved all available staff once that course of action was set out on. Staff explained that they now had personal alarms to activate if they required emergency support. One staff member had used the alarm recently and obtained an immediate response from colleagues, which was more effective in managing incidents. However these alarms only linked to The Villa and The Cottage, meaning that if staff were out with tenants, there was no way of summoning help. When at home with tenants other than the land line situated in the living room of the house, there was no way of summoning help from colleagues outside of The Villa and The Cottage, as the alarms only linked to the supported living service, not to the main Retreat site.

There was a culture within the units that restraint was a necessary course of action to take to prevent people harming themselves and others if their anxieties were acted out through aggressive behaviour. There was also a culture of secluding people in their bedrooms by locking their door if other people needed to be assisted during times when minimum numbers of staff were on duty. This was for a 12 hour period during the night when four waking night staff were on shift. Service users who were not independently mobile or had significant learning disabilities could not leave their rooms during these times. We witnessed one tenant ask one of our inspectors to summon staff to help her leave her room. Staff told us that all tenants could leave their rooms independently whenever they chose to, we saw that this was not the case.

The unit manager explained the locking of bedroom doors was not to keep people in their bedrooms but to keep people from going into each other's bedrooms during the night shift. They said that while doors were locked from the outside people in their bedrooms could easily open the locking mechanisms by just pulling on the door handles. We checked this was the case and found that one person permanently in a wheelchair due to their disability, could not independently release their door handle to exit the room. This person was therefore effectively secluded on occasions when staff locked their doors at night to assist another person.

This was a breach of regulation 13 (4) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the registered provider to take at the end of this inspection report.

There were risk assessments in place for people on an individual basis that included assessments of risk for going out in the community, being aware of traffic, slips/trips/falls, travel sickness in cars/taxis, support with personal allowance, behaviour due to anxiety and activities or trips out (swimming, cycling, boat trips).

There were accident and incident policies and records in place should anyone living or working in the units have an accident or be involved in an incident. Records showed that these had been recorded thoroughly and action had been taken to treat injured persons and prevent accidents re-occurring. However, there was an incident that occurred where staff were unaware of the person's diagnosed condition and it was not until after the incident that information was discovered that would have alerted staff to the risks the person faced.

Staff told us about the shifts they worked according to an eight week rotating roster. They told us they thought they always had sufficient staff on duty to meet people's needs and that rarely were staff off sick. They explained that people's activities were never cancelled as a result of any staff absence because of the high staffing ratios to people. Although there was a shortage of staff on the day we inspected, there was still sufficient staff on duty, nine in total, to ensure the planned activities for people went ahead and their needs were met.

Staff explained to us that one person initially came to The Retreat with funding for one-to-one support, but after staff struggled to ensure the person's needs were met effectively, a case was put forward to acquire

two-to-one support. Staff told us that another person had three-to-one support when they received personal care.

When we looked at the staffing rosters and checked these against the numbers of staff on duty during our inspection we saw that they corresponded. We saw that there were sufficient staff on duty to meet people's day-to-day care needs, but that at times of emergency the policies and practices of staff did not mitigate the risk of harm to people because staff did not always deploy themselves effectively to ensure risks to people were reduced.

The registered provider used thorough recruitment procedures to ensure staff were right for the job. They ensured job applications were completed, identities were verified and references taken, although one staff member's references had not been filed. They ensured Disclosure and Barring Service (DBS) checks were carried out before staff started working. A DBS check is a legal requirement for anyone applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Of the staff recruitment files we looked at we found all five had a photograph, contract of employment, medical questionnaire, confirmation letter of employment and an interview record. We assessed that staff had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable. However, we found that one member of staff had commenced employment without adequate references being received, we asked the provider to rectify this during our visit.

We looked at how medicines were managed within the service and checked a selection of medication administration record (MAR) charts. The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packets and divided into the required number of daily doses, as prescribed by the GP. It allows for the administration of measured doses given at specific times.

The service had received a medication audit from the supplying pharmacy on 26 May 2016, which had highlighted concerns. These included problems with ordering and receipting medicines, storing them and administering them and there were concerns about staff training in the management of medicines. These issues also related to controlled drugs (CDs). The unit manager explained to us how all of these issues had been or were being addressed.

The service had recorded two or three incidents since opening the units when medication errors had occurred. The unit manager told us that the plan was to move people's individual medicines into their own personal stores in their bedrooms, as the office where people usually received their medication was busy and noisy and staff were at risk of making more mistakes. This had not taken place yet.

We saw that medicines were obtained in a timely way so that people did not run out of them, that they were stored safely, and that medicines were administered on time, recorded correctly and disposed of appropriately. We saw that controlled drugs were appropriately handled in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001). Medicines were safely managed on the day of our inspection.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

We saw that people's documentation tried to show how the particular needs and the risks to their health or wellbeing, which they faced, had been addressed using the MCA legislation and best interest decisions. For one person, for example, there was a mental capacity assessment form which addressed the person's self-harming behaviour and the harming of others when they received personal care and support. Both part 1 and part 2 of the form were completed but there was no evidence in the file of a best interest meeting having been held to show how the decision had been made to hold the person's hands during support with personal care. Staff told us they felt there was a real blurring of the reasons why this person's hands were held and staff said they struggled with the fact that they were restraining the person.

The person was also restrained when out in the community in their wheelchair, with the use of wrist weights, which staff applied if the person tried to harm themselves or the staff supporting them. While we were given an explanation by the unit manager as to when the weights were used and why, we were not satisfied that staff fully understood these reasons or applied the weights for these reasons. This was because daily notes stated on one occasion that the person's wrist weights were applied to "Prevent them hitting out at staff." Staff also expressed to us in conversation that they used the weights to stop the person from harming staff when pushing the person in their wheelchair. The unit manager told us that the weights were easily removed by the person if they wished to do so and therefore the person was not forced to wear them.

This person also had a mental capacity assessment form to show how their relationships and friendships were best maintained for them, but there was no evidence to show that either part of the required form had been completed.

The notifications that the service had sent us regarding the restraints in December 2015 and April 2016 had been about physical restraints of people that involved the placing of people on the ground in the 'prone position'. Two restraints had been carried out for up to 10 minutes and a third had lasted 20 minutes. Since becoming aware of these the registered manager had notified us, made referrals to City of York Council safeguarding team and instructed all staff to immediately cease the use of restraints on the ground or in a 'prone position'. Staff told us they no longer used restraints to 'put people to the ground' but used 'arm holds' only in standing or sitting position. They said if a person lowered themselves to the ground when having their arms held, staff immediately disengaged.

Staff told us the registered manager had been searching for alternative behaviour management training that did not involve restraint but focused on de-escalation and distraction techniques. This had yet to be sourced and all use of any kind of restraint had yet to cease. However, the inspection team felt that what

had been changed so far was a positive move in the right direction to ensure people were not restrained. The culture of the service had yet to change and a complete halt on any restraint had not happened in favour of less restrictive options for delivering care and support in order to ensure people were kept safe.

Another person's documentation contained a mental capacity assessment form completed by their social worker in April 2016. There was evidence that a best interest meeting had been held to show the person was unable to make important decisions regarding their care and support, health and finances. A family member had taken out a 'lasting power of attorney' order to make decisions on their behalf for their care and finances. Staff at The Retreat had completed capacity assessments for this person regarding shopping, cooking and managing medication, but none of these assessments had been signed. Nor were the documents person-centred or in an accessible format for people with a learning disability.

A third person's documentation (care file) contained a section on their mental capacity assessment decision, which stated they had no capacity to make complex decisions; about their medical care, finances, taking medication, nutrition and seclusion behind a locked bedroom door while staff attended to other people. There was evidence to show how the person's capacity to make decisions had been assessed in the form of MCA assessments, but there was no evidence to show whether or not the best interest route had been used to make the decisions that had been made on their behalf.

There was evidence of best interest decisions for three of the six people that used the service in respect of moving to The Retreat before they actually moved. There was evidence that a best interest decision had been made for a fourth person after they moved to the service, evidence that a best interest decision had been made for a fifth person but in the form of an email only and the sixth person had no evidence of a best interest decision having been made at all for them to move to The Retreat. This was an inconsistent approach by the service and did not show that people had moved to the service in a way that protected their rights.

Where a person is deprived of their liberty in their own home or in supported living accommodation there must be a Court of Protection order in place first, which does not require the need for separate Deprivation of Liberty Safeguards. All service users were accompanied if they left the building. Although the front door was unlocked, tenants were unable to leave without support, and would be brought back by staff should they attempt to leave due to the risk of harm caused should they go out alone. We were told that Court of Protection orders were not in place for anyone and these had not yet been applied for. The registered manager explained to us that these had been discussed with the placing local authority and they understood that the local authority was in the process of making the applications.

This was a breach of regulation 13 (5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It was also in contravention of the requirement to have an order in place from the Court of Protection in respect of people in their own homes being deprived of their liberty and in the absence of any need for other Mental Capacity Act safeguards. You can see what action we asked the registered provider to take at the end of this inspection report.

The unit manager told us and we saw recorded evidence that the person who staff fitted wrist weights to and who was held by the hands when being supported with personal care had these interventions written up as part of their support plan.

We were told that one person had a seizure whilst on a community outing which had caused them an injury and staff had noted on the incident form that they did not know the person had epilepsy, they had also noted that they found this information at a later date. This meant that staff placed this person at risk by not

taking adequate precautions by knowing their needs before an outing was undertaken. We were told that another person started a fire in their bedroom and again staff did not know about the person's past risk of fire setting. People at The Villa and The Cottage had complex needs, with severe learning disabilities and autism and their needs had not been safely met in the service.

This was a breach of regulation 12 (1) (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the registered provider to take at the end of this inspection report.

We looked at three people's files and took detailed notes regarding the content of each file. We saw there was important information and some important documents missing from the files: details of people's assessed care and support needs, dreams/aspirations/goals, best interest meetings and parts 1 and 2 of MCA assessment forms (not always completed).

The registered provider had systems in place to ensure staff received the training and experience they required to carry out their roles. A general staff training record (matrix) was used to monitor and review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed.

There was evidence in five staff training files that staff had completed training in the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, three different types of preventing and managing challenging behaviour, safeguarding adults, child protection, food hygiene, epilepsy awareness, nutrition and diabetes, management of medicines, emergency first aid, fire safety, moving and handling and the organisations 'core partner' course. Updates or refresher training was due for some of the courses staff had completed.

Those staff that had completed management of medicines training were also competency assessed and checked. There were plans in place to introduce medication systems e-learning, to be provided by the dispensing pharmacy that supplied people's medicines.

The registered provider had an induction programme in place, gave staff regular one-to-one supervision and reviewed staff performance via an appraisal scheme.

Staff had the opportunity to study for qualifications in health care. In the five staff training files we looked at qualifications included the Advanced Level Apprenticeship in Adult Social Care, level 2 and level 3 Diploma in Health and Social Care and Electronic Data Interchange level 3. Staff told us about the qualifications they held, including those of qualified nurse.

We were told by staff that Mental Health Act training was mandatory for any nursing staff employed at The Villa and The Cottage but not for the support workers that were employed. It would be beneficial if all staff received Mental Health Act training as suggested in the Mental Health Act Code of Practice.

We saw five staff files that confirmed the training they had completed and the qualifications they had achieved. We saw that staff had received supervision regularly and that appraisal scheme meetings with staff were recorded. Staff told us they attended staff meetings whenever required to.

Staff explained to us they offered people choice wherever possible and looked for signs of consent being given or verbally expressed by them before providing people with the care and support they required.

Health care needs were assessed and monitored to ensure people received regular check-ups by their GPs

and if appropriate visits to their dentist and optician. One person's care file and support plan we saw contained information about their learning disability and diagnosed conditions and there was information on how best to meet the person's needs that presented because of these. It listed the social care and healthcare professionals that had a stake in the person's support and treatment: these included the person's social worker, their learning disability nurse, their speech and language therapist and their occupational therapist. It explained in precise terms how the person took their medication to maintain optimum health and avoid consequences of their conditions.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that thorough assessment of needs had not taken place at The Villa and The Cottage, for the people living at the service. This placed tenants and staff at risk of harm. Regulation 12 (1) (2) (a)

The enforcement action we took:

We submitted warning notices to the provider and the registered manager, which state that they must be compliant with this regulation by 15 July 2016.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found that tenants using the service were being restrained and deprived of their liberty without the proper lawful authority. Regulation 13 (4) (b) & (5)

The enforcement action we took:

We submitted warning notices to the provider and the registered manager, which state that they must be compliant with this regulation by 15 July 2016.