ANNEX 3

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

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.

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Summary of findings

Overall summary

We rated the Retreat York as **inadequate** because:

- In January 2017 hospital managers decided to move six patients to the previously closed Allis unit for a six week period. When we visited there were no patients on the unit, however Allis unit appeared dirty, damp and cold. There was limited hot water and unsuitable kitchen, toilet and bathing facilities. We saw a lack of proper planning and staff allocation in relation to the cleanliness of Allis unit. We did not see, and were told by one nurse that worked on Allis unit, that there was no grab bag on the unit; a grab bag contains items to use in an emergency such as resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another older people's unit directly below the Allis unit. There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited. Neither unit had an environmental risk register to identify and prevent risks to the patients that could have occurred because of the changes relating to the flooring refurbishment of George Jepson.
- We found there to be unsafe and unsuitable staffing levels and skill mix including the allocation and availability of qualified nursing staff on both Allis and George Jepson units. Staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.
- Units had ligature risks and blind spots that were not continually managed with observations. On George Jepson unit, patients were unable to use the conservatory, quiet room or access the garden. Staff could not always see patients on the unit when they were on observations. Staff locked entrance doors to the units and patients were not individually risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or access to the duty room.
- We saw no record of timely discussions with patients or families in relation to the move to Allis unit. We saw that families had concerns regarding the Allis unit and did not find evidence that the provider had prioritised patient dignity in terms of the move. We saw evidence that families told the provider how their relatives had been disoriented on both units when the flooring work was being completed and gave examples of when staff had become distracted and had been unable to complete their personal care.
- We saw no effective system for identifying, capturing and managing issues and risks at team and organisation level in relation to the flooring work on George Jepson during our inspection or in any of the information provided by the Retreat York. There were significant issues that threatened the delivery of safe and effective care and these were not identified.
- We saw no documented evidence of a multidisciplinary discussion around suitability of patients to move or the impact on the patients that remained on the George Jepson unit. The provider was unable to locate and evidence details of personalised risk assessments, environmental risk assessments and personal evacuation plans.
- Families told us that there were not enough activities for the patients on the unit and we saw this to be the case.

However:

- George Jepson unit was clean and smelt fresh in both communal areas and patient bedrooms. Resuscitation equipment was available, medicines storage was well organised and we saw staff using correct equipment when moving patients as detailed in patient care plans.
- We saw that the provider monitored incidents and acted on incidents reported. Families and carers of patients were informed of incidents when they occurred.
- Patients who were able to communicate told us that they liked being on George Jepson unit and that staff were kind. Families described the staff as caring and supportive and George Jepson unit as a wonderful place in spite of the shortcomings.
- All staff described their close working relationships and enjoyment of their roles. We observed staff to be friendly and caring to patients; staff considered patients' needs; we saw that patients that needed help with personal care were clean.

Summary of findings

Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report which we will publish in due course.

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Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Inadequate 	

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Summary of findings

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Inadequate

The Retreat York

Services we looked at

Wards for older people with mental health problems;

Summary of this inspection

Background to The Retreat - York

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

George Jepson unit is a 13 bedded unit located on the ground floor of the main building that provides specialist care and treatment for men who have a primary diagnosis of a functional or organic disorder such as dementia. It supports patients who may have challenging behaviour. There were 12 patients on the unit during our inspection.

George Jepson unit has been previously inspected on four occasions.

The previous inspection on 29 November 2016 rated wards for older people with mental health problems as requires improvement. We found that the following regulations were not being met:

- 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 patients' individual needs.
- 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 were suitably trained, competent and reviewed. Staff were not following policies and procedures about managing medicines, including those related to infection control.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing. The provider did not ensure that all staff received appropriate support, professional development supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

We have asked the provider to meet these requirements and provide an action plan.

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 for Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. We found that the provider had not ensured the proper and safe management of medicines and that patients at risk of falls did not have comprehensive plans in place to mitigate this risk including wearing safe footwear. During this inspection we saw that patients had falls risk plans in place, however two patients during the inspection had no footwear on until the nurse prompted staff.

We undertook 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.

The last Mental Health Act visit to the George Jepson older peoples unit was on 27 October 2015. We did not see evidence of a range of therapeutic activities on the unit. 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.

Allis unit is located in the main building of the Retreat York. Six patients were moved from George Jepson unit to Allis unit from 11 January 2017 to 3 February 2017. The provider previously closed the unit to inpatients in 2015 as it was unsuitable for the patient group that resided there. There were no patients on Allis unit on either occasion we visited the unit.

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

Summary of this inspection

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.

Our inspection team

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

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We carried out an unannounced inspection of this service after the provider informed us that 13 safeguarding alerts had been reported to them by two staff members on 03 February 2017. The alerts related primarily to staff delivery of patient personal care, inappropriate moving and handling of patients, and staffing shortages. These alerts also contained reports of bullying within the staff team. The reported incidents had occurred during the period the 11 January 2017 to 3 February 2017 when six patients from George Jepson unit were moved to another unit, the 'Allis' unit , while refurbishment work took place on the George Jepson unit. The provider had not informed the Care Quality Commission of their intention to move patients for a six week period. The provider previously closed Allis unit to inpatients in 2015 as they found it unsuitable for the patient group that resided there. There were no patients on Allis unit on either occasion we visited as the provider had closed the unit on 3 February 2017 in response to the safeguarding alerts.

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 we reviewed information that we held about the Retreat York. This information suggested that the ratings of requires improvement for effective and responsive domains, that we made following our November 2016 inspection, were still valid. Therefore, during this inspection, we focused on those issues relating to the safeguarding concerns in the safe, caring and well-led domains. As this was a focussed inspection relating to the safeguarding concerns for George Jepson patients we did not inspect the female older adult unit.

Before the inspection, the inspection team spoke with the chief executive officer, two nurses and one social worker regarding the safeguarding alerts that were raised and attended a safeguarding strategy meeting.

During the inspection visit, the inspection team:

- visited the George Jepson unit, looked at the quality of the unit environment and observed how staff were caring for patients;
- visited the Allis unit and looked at the quality of the unit environment;
- spoke with the acting unit manager for George Jepson unit;
- spoke with four patients who were using the service;
- spoke with two carers of patients on George Jepson unit;
- spoke with six other staff members; including cleaning staff, nurses and support staff;
- attended and observed one handover meeting;
- looked at 12 care and treatment records of patients;
- observed two mealtimes;

Summary of this inspection

- observed one patient having a hoist assessment;
- carried out a specific check of the medication management on the units; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients that were able to communicate told us that they liked being on George Jepson unit and that staff were kind. There were no patients on Allis unit on either occasion we visited as the provider had closed the unit on 3 February 2017 in response to the safeguarding alerts. Families told us that there were not enough activities for the patients on the unit. We reviewed meeting minutes where families told the provider that their relatives had been disoriented on both units when the flooring work was being completed and gave examples of when staff had become distracted and had been unable to complete their duties. We saw meeting minutes where families described the staff as caring and supportive and George Jepson unit as a wonderful place in spite of the shortcomings. We saw in meeting minutes and were told that carers had not been made aware of their relatives moving to another unit prior to the move taking place and best interest discussions had not taken place.

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?

Inadequate

We rated safe as **inadequate** because:

- Both units had ligature risks and blind spots. We found that staff could not always see patients on the unit. We found there to be unsafe and unsuitable staffing levels and skill mix on both units; during the move there was only one qualified nurse allocated to cover both units on a regular basis.
- Although there were no patients on Allis unit at the time of inspection, the unit was dirty, damp and cold; there was limited hot water and unsuitable kitchen, toilet and bathing facilities. We did not see, and were told by one nurse that worked on Allis unit, that there was no grab bag on the unit; a grab bag contains items to use in an emergency such as resuscitation equipment or emergency medications. The provider told us that the closest grab bag was on another unit directly below the Allis unit. There was no clinic room on Allis unit and medicines storage was not in keeping with best practice when we visited. On George Jepson unit cleaning charts were not available in all patient bedrooms and support staff were not adequately protected when cleaning.
- On George Jepson unit patients were unable to use the conservatory, quiet room or access the garden.
- Neither unit had an environmental risk register relating to the flooring refurbishment of George Jepson.
- On George Jepson unit staff were unable to spend meaningful time engaging with patients as they were responding to other patient needs.
- Patient risk plans were not all up to date and there were no patient risk assessments relating to the flooring work being completed on the George Jepson unit.
- Doors were locked on the units and patients were not risk assessed to be able to leave the units unescorted or without permission. Not all staff had swipe fobs to be able to leave the unit or access to the duty room.
- Not all incidents were reported on the provider's incident management system; this meant the provider could not act on minimising all risks to patients.

However:

- George Jepson unit was clean and odour free in both communal areas and patient bedrooms.
- Resuscitation equipment was available on George Jepson unit.

Summary of this inspection

- The provider used contracted agency staff that were familiar to the unit and patients where possible.
- On George Jepson, medicines were stored in a locked trolley that was attached to the wall. All medicines were in individually labelled boxes with patient names.
- Staff used the correct equipment when moving patients as detailed in patient care plans.
- The provider monitored incidents and acted on incidents reported; Families and carers of patients were informed of incidents when they occurred.

Are services effective?

Requires improvement

At the last inspection in November 2016 we rated effective as **requires improvement**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

Are services caring?

Requires improvement

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

- Families told us how their relatives had been disoriented on both units when the flooring work was being completed and gave examples of when staff had become distracted and had been unable to complete their duties.
- We saw no record of timely discussions with patients or families in relation to the move. We found that families had concerns regarding the Allis unit and did not find evidence that the provider had prioritised patient dignity in terms of the move.
- Staff were not able to see all patients during mealtimes and one patient was served multiple courses at one time which resulted in cold food.
- Patients did not always have appropriate footwear on the unit. We had highlighted this as a safety issue in a previous Care Quality Commission inspection.
- Families told us that there were not enough activities for the patients on the unit; the activities board was incomplete during our inspection and we saw no activities taking place.

However:

- Patients who were able to communicate told us that they liked being on George Jepson unit and that staff were kind. Families described the staff as caring and supportive and the unit as a wonderful place in spite of the shortcomings.
- We observed staff to be friendly and caring to patients; staff considered patients' needs; Almost all of the patients were clean and personal care was being attended to.

Summary of this inspection

- Patients were mostly using specialised eating equipment at mealtimes.
- Patients had access to and made use of advocacy services and the provider welcomed advocacy services on the unit.

Are services responsive?

Requires improvement

At the last inspection in November 2016 we rated responsive as **requires improvement**. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The provider had no effective system for identifying, capturing and managing issues and risks at team or organisation level in relation to the flooring work on George Jepson during our inspection or in any of the information provided by the Retreat York. There were significant issues that threatened the delivery of safe and effective care and these were not identified.
- We saw no documented evidence of a multidisciplinary discussion around the suitability of patients to move or the impact on the patients that remained on the George Jepson unit.
- The provider was unable to locate and evidence details of personalised risk assessments, environmental risk assessments and personal fire evacuation plans.
- The provider had not ensured the staff and facilities needed for cleaning the unit properly were in place prior to and during the patient move to Allis unit.

However:

- All staff described their close working relationships and enjoyment of their roles.

Detailed findings from this inspection

Mental Health Act responsibilities

We did not review Mental Health Act responsibilities during this focused inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Mental Capacity Act and Deprivation of Liberty Safeguards during this focused inspection. However we did note that there were no best interest discussions in relation to the move for patients that lacked capacity. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Inadequate	N/A	Requires improvement	N/A	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Notes

At the last inspection in November 2016 we rated effective and responsive as requires improvement. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating. Ratings from our previous inspection for these domains are reflected in the current ratings for The Retreat York.

Inadequate

Wards for older people with mental health problems

Safe	Inadequate
Caring	Requires improvement
Well-led	Inadequate

Are wards for older people with mental health problems safe?

Inadequate

Safe and clean environment

George Jepson unit

The George Jepson unit consisted of two corridors in an L shape. The unit had blind spots (areas where staff could not see patients at all times). There was an increased risk of harm to patients because the unit contained ligature points. A ligature point is something, which people can use to tie something to in order to strangle themselves. These risks were mostly managed by the provider in line with their observation policy, and individual patient risk plans. The unit was trialling a new observation approach on the morning of our inspection. Observations were used to keep patients safe; when a patient was on a higher level of observation staff were required to check on the patient's whereabouts on a regular basis. The unit comprised of three zones and one member of staff was allocated to each zone. This was to allow staff to know the whereabouts of all of the patients at all times in order to keep them safe. The unit also had an additional two floating staff to support with personal care of patients.

The unit had a fully equipped clinic room available to allow staff to examine and treat patients. The clinic room had a grab bag and resuscitation equipment available and we saw that staff checked and audited these regularly. There was a defibrillator available, and the room was clean and tidy. The unit did not have a seclusion room and when we saw patients becoming agitated, staff distracted them to calm down. The unit was clean and tidy and we saw one domestic staff on duty. Patient bedrooms were clean and odour free. We saw nursing support staff taking patients for breakfast and then returning to patient bedrooms to change sheets and wipe down beds with sterile wipes.

However, staff were not adequately protected and wore no apron or gloves. Cleaning charts were not available in all patient bedrooms. This increased the risk of infection because staff did not follow infection control procedures to protect themselves and patients.

The unit was in the process of refurbishment work to the floor when we visited. The provider had halted the flooring work on George Jepson to settle the patients back on the unit. The Retreat York held a Leadership meeting on the 21st February 2017 to agree the most appropriate way to complete the work. The incomplete flooring was completed by the end of the following week, three and a half weeks after the patients had returned to George Jepson unit. Staff told us that the floor was being refurbished because it was scratched and did not look clean. In order to keep patients safe until the works were completed, staff had sectioned off an area where the uneven concrete floor (approximately one and a half centimetres lower than the rest of the floor) was exposed by placing four armchairs to block patient access. The sectioned off area included one bathroom, one bedroom (both not in use by patients) and access to the fire escape. This meant that patients would need to cross this area to access the fire escape. The uneven floor increased the risk of falls for patients who were already assessed as having poor mobility. We witnessed one patient pushing a wheelchair and another patient self propelling in a wheelchair towards this area. We also saw one patient was able to easily move one of the chairs, leaving the area accessible. Although staff were present on the corridor observing patients, they were not always at the end of the corridor where the flooring was incomplete, and this was potential risk to patient safety. We sought reassurance from the provider who told us that patients were using the area as an additional seating area and that no incidents had occurred in the time that the floor had been unfinished.

As a result of ongoing work to the George Jepson unit flooring, the unit had turned the quiet room, which was at the entrance to the unit, into a patient bedroom. The room

did not have space for patients to store their personal belongings or clothing. Clothing was being stored in a laundry basket on the floor. The room still had a fully stocked bookcase and sofa left from its previous use. The patient's room had not been personalised. Privacy and dignity could not be maintained in the room as it had viewing panels and windows which faced two unit corridors. The unit had a quiet room, a dining room, a lounge and a conservatory for patients to use. However neither the conservatory nor the quiet room was available to the patients to use when we visited. The conservatory was cluttered and filled with patient belongings from the move to Allis unit. It was not possible for patients to access outside space as a result. Three patient care plans referred to the patients being able to access outside space as a way of calming them down should they become distressed. Maintenance staff from the Retreat York moved some of the belongings during the inspection and another member of staff commented that it was good to have another room for the patients to use. The quiet room was being used as a patient bedroom as an interim measure.

The dining room was small and clean. At mealtimes, patients chose to eat meals in the dining room, lounge or on the corridor. However not all patients could be seated in the dining area with staff supporting mealtimes at any one time. We observed one staff member not wearing an apron or head cover serving food to a patient in the kitchen; however staff adhered to the provider's hand washing policy and washed their hands prior to serving. We also observed that one member of staff had to break off feeding a patient on the corridor to redirect another patient away from the dining room to prevent a negative patient interaction. The patient was unable to feed themselves and required support from staff to eat. We saw that the fridge in the kitchen on George Jepson unit was used by staff to store personal food and drinks. For some items it was unclear where they had originated and not all food was dated.

One agency member of staff pointed out that a basin of urine was left on a chair in the hallway when they were on shift. They told us that they had worked on the unit before however when we saw them being assigned to a corridor for patient observations they did not know where to go. The provider told us that the staff member had worked at the Retreat before and a form was completed and signed confirming that the agency staff member had read all the policies and received orientation.

Staff had not completed the orientation board in the hallway fully. It showed the month and the weather but not the date. One patient's care plan suggested using the board to help orientate the patient; this was not possible on the day of our inspection. We also saw that the staff on duty board had not been completed and the feedback about the unit on display was from September 2016.

We asked the provider for a copy of the environmental risk assessment for the unit in preparation for the work being completed. They told us that it did not appear that an environmental risk assessment had been completed in advance of the work and that disciplinary procedures were being followed with staff involved in the planning because of the increased risk this highlighted for patients and staff.

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. We witnessed the alarms being used when we visited.

Allis unit

We visited Allis unit on two occasions; the first on 9 February 2017, three days after the safeguarding alerts had been received and the second during our unannounced inspection. Allis unit is located on the second floor of the Retreat York main building. There were no patients on the unit on either occasion; all patients had been moved back to George Jepson unit on 3 February 2017 in response to the safeguarding alerts. Staff had reported that the environment was damp and cold and we visited to gain an understanding of the unit where the patients had been relocated to.

The Retreat York had previously closed Allis unit in 2015 as they considered it unsuitable for the patient group that resided there. During the period 11 Jan 2017 to 3 February 2017 six patients were relocated to this closed unit so that the flooring work on George Jepson could be completed. We also saw in handover and activity notes that one more patient from George Jepson unit had visited Allis unit on one occasion. We asked the chief executive officer if they knew of any additional patients visiting Allis unit from George Jepson unit and they told us that they were unaware of this visit.

Allis unit had a long corridor with rooms on either side. The environment was dirty in places with damp patches on walls and ceilings in communal areas such as bathrooms,

Wards for older people with mental health problems

lounges, hallway and patient bedrooms. Staff that had worked on Allis unit told us that the provider had renovated the unit in advance of patients moving, this included painting one patient bedroom to cover mould on the walls. Two of the sofas on the unit had a cushion removed or cushion covers removed.

Although meals were delivered to Allis unit, staff used the kitchen to make hot drinks and prepare snacks for patients. At the time of our visits the kitchen was damp and unclean. Staff told us that there was limited access to hot water on the unit and that they would carry water from the kitchen to patient rooms to help complete personal care. Staff said this was difficult if a patient had to be restrained for personal care.

We spoke with cleaning staff at The Retreat York and reviewed the cleaning communication book. Staff told us that one member of staff had cleaned the unit the day before patients from the George Jepson unit were moved onto Allis unit. We saw an entry in the cleaning communication book that commented that one member of staff had cleaned Allis unit from 10am to 1pm. We saw no clear plan to identify what cleaning needed to be completed in advance of the move. When we visited the unit, we saw blood in the top drawer of one patient's chest of drawers in their bedroom and faeces on another wardrobe door handle. The communication book showed that cleaning staff had queried how the unit was to be serviced for the six week duration when the patients were scheduled to be on Allis. The cleaning staff suggested a basic service, with all staff including clinical, 'mucking in'. On Allis unit we saw a cleaning task list for the unit night staff to complete but saw no records documenting that the tasks had been completed. We also saw in the communication book that a bottle of sanitizer was left in one patient's bedroom on Allis unit; we saw no incident report for this on the provider's incident reporting system.

On 3 February 2017 one member of staff commented in the communication book that patients were being moved back to the George Jepson unit due to the environment on Allis unit. They described the patients as having chest infections and one patient being admitted to hospital due to a chest infection.

We had concerns about the possible inappropriate storage of medications when patients were on the unit. The medicines fridge was located in the kitchen used for preparing food and drinks. Although there were no medicines in the fridge when we inspected, it was unclean and stained on the inside; this is not in line with infection control and medicines management guidance. The medicines trolley was stored in a room which appeared damp and was filled with boxes, when we visited parts of the floor had been lifted exposing pipework. Royal Pharmaceutical Society guidance recommends that 'the storage of medicines needs to be in the right place. Filing cabinets are not suitable for storing medicines, neither are: kitchens, bathrooms, toilets, sluices, windowsills or areas next to heaters. These places are too damp or too warm (or both) or unhygienic for storing medicine.' Humidity can also impact on medicines and as such the provider should follow manufacturer's instructions and risk assessed prior to storage.

On Allis unit there was not a fully equipped clinic room available to allow staff to examine and treat patients. Staff told us that there was no grab bag or resuscitation equipment available on the unit. The provider told us that in the event of an emergency, the care coordinator allocated to the shift would collect the grab bag from reception when responding to an incident. The provider later told us that there was another grab bag available on the female older people's unit on the floor below. The Royal College of Psychiatrists' standards identifies that emergency medical resuscitation equipment (crash bag), should be available within three minutes; we found that this would be unlikely for the crash bag in the reception area as the time is dependent on the fitness and location of the staff responding. The other crash bag on the female older people's unit would be accessible within three minutes providing it was not in use. The provider shared a plan in relation to the move completed by the unit manager. The unit manager's action plan stated that one member of staff on each shift was to be allocated the role of basic life support and fire warden. We saw no record of this in the handover notes that we reviewed. The plan associated with the move had no dates for completion, sign off of actions completed or action owners.

There was one shower room with commode on Allis unit and one bathroom. The shower had a high step into it and was unusable by patients at risk of falls on the unit. Staff told us there was no hot water in the shower. We were told of incidents where staff had to use foam soap to support patients with incontinence with their personal care as there was no bath suitable for patient use on George Jepson unit and they were unable to use the shower on Allis. We saw no

evidence of the lack of facilities being recorded as an incident on the provider risk register or incident reporting system. The maintenance lead confirmed that there was an issue with the shower but this had not been reported to the maintenance team by staff on Allis unit. The provider could not confirm exact dates when both baths on George Jepson unit were available. They told us that the bath that was in working order was not suitable for the majority of the patient group due to its size and accessibility.

Access to the bathroom on Allis unit was up a ramp and handrails were available. However cubicles were not large enough for staff to support patients using the toilet. We saw an incident recorded where a patient had locked themselves in a cubicle; this resulted in a fall that was preventable.

The unit contained ligature risks and blind spots. Two patients' risk plans indicated they were at risk of suicide; these had not been updated for the move. We did not find that staffing levels limited the potential risks associated with the environmental. The provider told us that during the move no additional staff had been arranged; staff allocated to George Jepson unit also supported Allis unit. There was no formal rota in place differentiating staffing on the units. Staff told us there were three members of staff on the Allis unit to support the five patients that had been relocated there in order to finish the flooring work on George Jepson unit; we saw this recorded in handover notes. The Retreat York completed a review of staffing levels for the duration that the patients were on Allis and identified that a nurse was not always on the unit.

Two patients who moved to the unit had chest infections prior to the move. When we visited Allis unit on 08 February 2017 we found that the unit's temperature fluctuated between rooms; for example one patient's bedroom was very cold and the dining room was too hot. One member of staff told us the environment was cold in places, but that the heating was on when the unit was in use.

Allis unit was accessible via one passenger lift, one goods lift or stairs to the second floor. Staff told us that the lifts were not working consistently. The Retreat York provided incident data from 1 October 2016 to 11 February 2017 and we saw one incident where a patient became irate as both the passenger and goods lifts were not working.

At the time of inspection we found the premises and facilities on Allis unit to be unsafe however there were no patients located on this unit during the inspection period.

Safe staffing

George Jepson unit

The staffing establishment was set at two nurses (or one nurse and one occupational therapist) and five support workers on each day shift from 7am to 8pm. Night shift, which was from 7:30pm to 7:30am, had allocated one qualified nurse and four support workers on shift. This allowed for time for staff to handover information to the new shift each morning and evening. The unit also had a twilight shift where one member of staff worked until 11pm to support the busiest time on the unit. Where there was no twilight shift we saw that the provider increased the number of staff on a night shift. The staffing establishment did not include additional staff for one to one observations and only ensured coverage of zonal observations. During our inspection one patient was on one to one observations and planned staffing levels accommodated this. We reviewed the patient care records and saw that six patients were also on high level observations. This meant that staff on environmental observations had to know their whereabouts at all times to maintain patient safety. We observed this to be difficult during our inspection.

When we visited the unit, there was a qualified nurse on duty and six support workers on night shift. This was one more support staff than on the planned rota for the shift.

We attended the morning handover meeting at the start of the day shift; there was one qualified nurse and five support workers. Of nine members of staff scheduled to be on shift, one had phoned in sick, one was late and another staff's whereabouts were unknown. Staff discussed all patients from the previous 24 hours at the meeting. The acting unit manager explained a change to the unit's observation protocol in response to the recent safeguarding alerts. The change primarily focused on staff duties; the unit had reallocated staff so that there were now two 'floating members' of staff whose role it was to support patients with personal care needs including personal hygiene and fluids intake as well as observations. Staff were encouraged to be vigilant and pre-empt negative patient on patient interactions. The acting deputy unit manager explained that this new protocol would be reviewed and reassured staff that additional support from other staff was available to them if needed, for example

from the nurse in charge. Staff response to the change in process was mixed; we observed one member of staff ask another about the new system, the staff member responded saying it was not their problem.

We spoke with four staff members who told us that where possible the provider used reliable contracted agency staff. However, three members of staff also told us it could be difficult when new agency staff were working on the unit. One member of staff told us that there were a number of staff off sick and it felt like there was one new agency staff per shift as a result. We did not request additional sickness data from the provider. However at our last inspection in November 2016 sickness and absence rates on George Jepson unit were below the organisation's target of 3%. We did however identify that there had been an issue with staff retention; George Jepson had nine staff leavers in the previous 12 months (35%). We did request that the provider send us copies of the actual staffing rotas to compare with the planned rotas but this information was not received. Staff told us that they were regularly understaffed and that they were unable to carry out additional therapeutic activities with patients such as baking and art. One staff member told us that there were not a lot of activities for patients. This was the case during our inspection. We saw only one day had activities listed on the weekly planner board during our inspection. In the afternoon of the inspection there was music group facilitated by the occupational therapist; this was not reflected on the weekly planner board. We saw that some patients attended this group with their family members. Staff tried to engage with patients, one member of staff gave a patient a sensory ring while they were sat in the corridor and another was reading to a patient but staff were limited in providing meaningful engagement due to the level of patient observations and shortage of staff.

One staff member told us that they were worried that the unit was understaffed and were concerned that something may happen if staffing levels continued. Two members of staff told us they were worried about the levels of patient aggression on the unit. During our inspection one member of staff was assaulted by a patient.

There was not always a qualified nurse in communal areas at all times. There were periods of understaffing or inappropriate skill mix, which were not resolved quickly. The agency staff to replace one support worker that had called in sick was not on shift for three hours after being notified and the second nurse was not replaced on the unit when we were there. We observed the nurse in charge completing the morning medicines round. The medicines round lasted three and three quarter hours from start to finish. All patients, except one, were taking medications. The nurse in charge explained that medicines round was usually conducted by two nurses, however this was not possible as the second nurse on the rota was unwell. We saw that the nurse dispensing the medication was not wearing anything to identify that they were conducting the medicines round and was interrupted by other staff throughout.

Allis Unit

There was no formal rota in place differentiating staffing between the units. Staff told us there were three members of staff on Allis unit to support the five patients moved from George Jepson unit for the period 11 January to 3 February 2017. On handover sheets we saw that three staff were on the early shift, two or three staff on the late shift and one member of staff on the twilight shift. The recording of night staffing was inconsistent; we were unable to confirm staffing numbers. A qualified nurse was not always on the unit. The Retreat York provided nurse allocation information from the 11 January 2017 to 3 February 2017. This showed that of the 72 shifts when patients were moved to Allis, there were 48 shifts (67%) where there was one qualified nurse on shift to support both the George Jepson and Allis units. We found there to be a shortage of staff on the unit and found that this increased the risks to the patients. One incident reported on the provider's incident management system occurred when all staff on the unit had left their tasked observations to support another patient on the unit with personal care. Staffing levels were not high enough to accommodate this.

Assessing and managing risk to patients and staff

George Jepson Unit

We reviewed all patients' fluid charts from the previous day and saw that staff recorded times and the volume given. Fluid balance is essential for patient health and wellbeing. Six patients were recorded as having five drinks or less and the other six patients had up to eight in the previous day.

We reviewed three electronic patient care records during the inspection and requested copies of all care records to review them in more detail. All patient care plans had a risk plan that detailed triggers for challenging behaviour for

patients and a positive behavioural support plan with preventative strategies. However, of the three records we reviewed during the inspection, two patients had overdue risk plans. We requested dates of completed risk assessments for all patients from the Retreat York but this was not provided. We also asked the provider for evidence of individual risk assessments being completed prior to the refurbishment on the unit as the flooring work would create additional risk to the patients. The provider could not locate individualised risk assessments in relation to the flooring work.

A review of care plans showed that 11 of the 12 patients on the George Jepson unit required help from staff with personal care. Personal care included dental hygiene, support to move positions to prevent bed sores, and support to manage continence. The safeguarding alerts highlighted a lack of personal care being completed as an area of concern on Allis unit. We saw no evidence of patients not being attended to during our inspection of George Jepson for these areas of personal care. When a patient needed support, staff helped them immediately. However we noted that one patient was unshaven and another patient's teeth were dirty. One patient's jumper had a large patch of dried up food across the front.

Care plans detailed the nutritional needs of the patients. The safeguarding alerts highlighted fluid intake as an area of concern that staff were not supporting patients to drink enough and there was a risk of dehydration. We reviewed notes in the unit communication book asking staff to give patients the opportunity to drink; the unit communication book also asked that where patients declined a drink, staff should document this as the unit had identified gaps in recording. The dietician used this book to communicate with other unit staff when to increase fibre and fluids for patients, however the entry was not dated. Another two entries asked which staff had recorded two patient's fluid intake because it was not visible.

We viewed seven falls risk plans within the care plans. Where a risk was identified, there were well detailed plans in place. Falls risk plans for patients with increased risk were to be updated monthly. They detailed how staff were to move trip hazards, medications that increased the likelihood of falls, correct footwear for patients, identified the need to review at multidisciplinary team meetings and the incident reporting system to follow. Some patients had a bed sensor, roll mat and alarm. During our inspection we saw that two patients were not wearing appropriate footwear until support staff were prompted by the nurse in charge. One patient's falls plan indicated that there was a broken bone as a result of a fall; this patient was identified as being a low risk because staff were to be present to prevent any falls. During the inspection we did not see sufficient staff on the unit to do this. Falls risk plans were located in the locked duty room on the electronic record system, however not all staff had keys to access this room.

The most common reason for patients being restrained was for personal care. One family member described how their relative had progressed from four staff supporting with personal care to two. Another family member told us that they had never seen any bruises on their relative when they visited the George Jepson unit. The safeguarding alert identified that staff may not be following care plans to move patients safely. We saw one entry in a patient activity note where two members of staff correctly used a handling belt. During our inspection we saw no inappropriate holds of patients and observed a hoist assessment being conducted for one patient on the George Jepson unit. George Jepson did not have its own hoist so borrowed one from another unit at the Retreat York. This could cause delays to patient care and could leave a patient uncomfortable.

We saw blanket restrictions in place on the unit. 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 on the unit and informal patients could not leave without staff permission or support. We saw that one care plan referred to the unit as a 'locked unit'. We saw no evidence that individual risk assessments were undertaken in relation to leaving the unit so the locked door applied to all patients including one informal patient on the unit.

We reviewed the provider's risk register for 2016 -17. The provider had recorded a risk in the George Jepson environment because they felt it did not meet the required standards for dementia environmental audit or accreditation in October 2015. There was one completed item from 31 October 2016 associated with the flooring being completed on George Jepson; the action was to consider using another unit whilst redecorating in order to reduce risk of distress to patients. The action description identified that the move had to be carefully planned with leadership team and staff on George Jepson. We saw no

effective system for identifying, capturing and managing issues and risks at team and organisation level in relation to the flooring work on George Jepson during our inspection or in any of the information provided by the Retreat York. We viewed unit meeting minutes that referred to the risk register item; however we could not confirm who attended as the minutes did not detail this.

Medicines were stored in a locked trolley that was attached to the wall. All medicines were in individually labelled boxes with patient names.

We reviewed 11 prescription charts. All charts had allergy stickers to indicate allergies. We found covert medication was recorded monthly, with the exception of one patient where there was no record for one month. We reviewed eight psychotropic monitoring forms; one had no date identifying when the test had been completed in the notes, another patient had no form. Best practice recommends physical health monitoring that is required for someone taking psychotropic medication. Where appropriate second opinion appointed doctors reports were attached. A second opinion appointed doctor is a doctor appointed by the Care Quality Commission in order to review a detained or a community patient's treatment where this is required by the Mental Health Act.

Allis Unit

Patients from George Jepson unit were moved to Allis unit from 11 January 2017 to 3 February 2017 to continue the flooring work on George Jepson unit. As part of the inspection on George Jepson unit we reviewed patient care plans and risk plans for five patients that were located on Allis unit. Although care plans included National Institute for Health and Care Excellence guidance, triggers and symptoms and positive behavioural support plans, we also saw that there were no individual risk assessments completed for the refurbishment on the George Jepson unit or the move to Allis unit.

We reviewed five falls risk assessments for the patients on Allis unit. We found that one patient was categorised as low apparent risk of falls but also as a high risk of falls and so the information contradicted itself. There was a detailed entry explaining that specialist equipment was necessary to move the patient after a fall yet there was no hoist on Allis unit.

We also saw in reported incidents data, submitted by the provider, that staff were asked to keep the doors locked on Allis unit when the patients were on the unit but we did not inspect when patients were on the unit.

We saw that two patients care notes recorded details of chest infections. By the time all the patients had returned to George Jepson unit, five of the six patients had a chest infection or flu like symptoms; two patients had also been admitted to the local acute hospital with bronchial infections where one patient subsequently passed away.

The provider sent the 2016-17 George Jepson and provider risk register. The provider had referenced patients moving to Allis within one George Jepson environment risk but there was no separate risk identified for Allis unit in terms of the suitability of the environment for the patient group or consideration of staffing risks.

Reporting incidents and learning from when things go wrong

George Jepson Unit

Staff knew how to report incidents and we saw some evidence of this. However, agency staff, including those with longer contracts, were unable to access the incident reporting system. Agency staff would report incidents with the help of permanent Retreat staff. We saw incidents in staff communication books and handover notes that were not reported.

The provider submitted incident data from 1 October 2016 to 11 February 2017. Staff frequently misspelt patient names; one patient had five different spellings and versions of their name including one entirely incorrect surname. There were 140 incidents reported for both units during this period. One incident raised that on one occasion there had been no permanent staff on the unit on night shift; all were agency. The nurse in charge had never worked on the unit and the support staff had varying levels of experience. The day nurse lent their personal access card to the unit so that staff could leave the unit. Agency staff did not have training or access to the electronic record system or incident reporting system. This meant that agency staff were unable to log incidents on the provider system. We saw another two records where the only member of staff with an access fob left the unit to support Allis unit; This left all patients and staff locked on the unit for half an hour on two occasions. In the event of a fire, staff and patients would not have been able to leave the unit. The provider told us

Wards for older people with mental health problems

they now had a sign in and sign out book for swipe access and keys. During the inspection we saw that not all staff had access to the duty room on the unit; this is where the patient records were kept, so limited access could impact on patient safety if staff needed to refer to care plans or documentation in the duty room. We saw that staff were able to leave the unit with swipe access fobs.

Allis Unit

We received incident data provided by the Retreat York. Between 11 January 2017 and 26 January 2017 the provider reported 16 falls incidents on Allis; of these 15 were for one patient. There were two instances where this patient had been found on the floor. The patient's care plan showed that staff were to check the patient every 15 minutes and have an awareness of where the patient was at all times. We excluded the 15 instances over the 15 day period when the patient was on Allis unit and saw that the provider had recorded 10 falls over the other 119 days for the same patient.

The Retreat York had identified this increase in falls and addressed this with the unit manager. The unit manager told the provider on 2 February 2017 that this increase was due to the worsening of a physical illness that the patient had. The provider told us that that patient's GP and physiotherapist agreed with this. We also saw that a patient with a known risk of falls had left Allis unit and was found knocking on the door to another unit down one flight of stairs. The staff on Allis unit told the provider that all three staff on shift were required to support a patient in a bedroom and as such left their allocated corridor observations. In addition to this, the front door to the Allis unit had been left unlocked and the patient had been able to exit the unit and descend the stairs. Although no harm came to the patient there was the potential for a more serious incident to occur. There was one nurse allocated to both wards on night shift when the incident occurred increasing the risk of an incident occurring. The patient was returned to George Jepson unit the following day.

We saw in care plans that two of the six patients who had been moved to Allis unit had a history of pneumonia and chest infections. One of the patients with a history of chest infections was admitted to an acute hospital for treatment relating to a bronchial condition and later passed away. Another patient from this unit was also admitted to the local acute hospital with a chest infection from Allis unit. There were ligature risks on Allis unit and we saw that two patients had a history of suicide attempts. We reviewed incident data and saw that on one occasion staff did not remain on their assigned observation points which increased the risk to patients in terms of ligatures.

Additional incidents logged on Allis unit included a patient locking themselves in a bedroom for an unknown length of time until the staff on shift realised they were not present; this period could have been up to 1 hour 45 minutes. The incidents log also showed that two patients were saturated in urine when staff arrived for the early shift, as well as four incidents of patient on patient or staff assault by patients.

Staff and families told us that the provider contacted families to notify them of the safeguarding alerts for Allis and George Jepson units. The involvement lead and the chief executive officer met and telephoned relatives to discuss the incidents.

Are wards for older people with mental health problems caring?

Requires improvement

Kindness, dignity, respect and support

George Jepson

Patients who were able to communicate told us that they liked being on George Jepson unit and that staff were kind.

We observed staff to be friendly and caring to patients. Staff explained what they were doing when they were helping patients and asked their permission before acting; for example, when putting a clothes protector on a patient at mealtimes. We witnessed one member of staff going into the dining room and hallways to say hello to all of the patients at the start of their shift. We saw staff smiling and laughing with patients and meaningfully stroking patients' hands for comfort. Where staff needed help moving a patient safely they sought help from another member of staff. Staff considered patients' needs; we saw one staff member making fresh toast for a patient where theirs had gone cold.

We observed warm, respectful interactions with patients during the medication round, and the nurse in charge talked with the patients throughout. The nurse in charge addressed patients at their level and kneeled to engage with patients who were sitting down.

Wards for older people with mental health problems

At lunchtime we saw that one patient had their hot custard pudding served at the same time as their main meal. The patient had no plate warmer and the duration of the meal meant that the patient's pudding was cold when they had finished their main course. This had been highlighted as an issue in the recent safeguarding alerts.

Staff encouraged patients to feed themselves with their own cutlery where possible.

We observed patients the majority of patients who needed support with personal care to be clean, well dressed and in their own clothes. However we noted that one patient was unshaven and another patient's teeth were dirty. One patient's jumper had a large patch of dried up food across the front. We also observed two patients wearing no footwear until the nurse in charge prompted staff during the medicines round. Inappropriate footwear was previously identified as a safety issue on this unit on a previous Care Quality Commission inspection.

There was not always a member of staff in the dining room or lounge with the patients when they were eating; staff would not be immediately aware if patients were to choke. Five patients on the unit had a choking risk identified in their risk plans.

We observed that some patients had specialised eating equipment, such as red bowls, lipped cups and plate warmers.

Families and carers were welcome on the unit. We spoke with two family members during our inspection. Families told us that regular staff on the unit were friendly and kind, however they also told us that the unit was in disarray and described the staff as 'run ragged'. One family member told us that the quality and variety of food was good, but their relative's food was cold when she visited at a mealtime. Relatives told us that there had not been an updated activity board recently and that evening and weekends had fewer activities for patients. We saw only one day had activities listed on the weekly planner during our inspection. Relatives also told us that staff attempted to engage with patients and include them in activities. Family members told us that their relatives were bathed regularly and that the unit was clean and tidy.

One family member told us that agency staff did not interact with patients in the same way when they were new in comparison with other staff, another family member told us that agency staff did not know their family member as well as other staff.

Families told us that contacting the unit via telephone was difficult.

Allis unit

We reviewed the activity notes of five patients that were relocated to Allis unit for the period 11 January 2017 to 03 February 2017.

We saw scheduled activities including a music group, sensory group and pets as therapy dog visit. The chaplain, psychology team, dietician and physiotherapy all visited the patients on the unit. We saw that patients were asked if they wanted to go out and engaged in non-arranged activities such as painting and trips to the Quaker pantry (which is an activities room on the ground floor of the Retreat York). We saw that patients played skittles, played with balloons and reminisced. One patient went out for lunch. However we also saw significant reference to patients sitting on the sofa and being in bed when there were no activities on the unit; activities were not recorded as occurring on a daily basis. We saw in handover notes that one patient slept on the sofa for the night. The majority of staff did not recognise the safety concerns relating to the unit and did not escalate concerns further than the unit manager.

Staff told us that some patients found the environment confusing and others were happy on Allis unit.

The involvement of people in the care they receive

George Jepson Unit

Patients had access to and made use of advocacy services and staff from advocacy services were welcomed on the unit.

Family members confirmed that they were involved in care planning and one relative told us that they were invited to multidisciplinary team meetings; when they could not attend, the psychiatrist on the unit had telephoned them with updates. One relative described their relative's care plan in their room and said that the unit promoted patient

independence. We saw evidence in all of the care plans that families were involved in care. We saw that patients who had an advance decision in place were visible in patient care plans and handover sheets.

We reviewed emails and meeting minutes where the provider had informed families of the safeguarding alerts. One relative described communications as poor and said that staff did not always complete personal care observation sheets to indicate when their relative had been attended to. Carers also said that staff struggled to attend to the personal care of all the patients on the unit. During an afternoon visit, one relative described their family member as cold and only partially dressed. We did not see an incident recorded for this. The following day they found their relative warm and dressed.

Families felt that unfamiliar agency staff were a problem when they don't know the unit and thought that the unit manager should be more visible on the unit.

Families also described the Retreat York as a wonderful place in spite of the shortcomings and described the chief executive officer as visible and approachable.

Allis Unit

We reviewed emails and meeting minutes where the provider had informed families of the safeguarding alerts and spoke with two relatives during the inspection.

One family member spoke of the move of their relative to Allis unit. They told us that they had been contacted and told the day before the move. Staff at the Retreat York also confirmed that families had only been informed on the day before or on the morning of the move. We saw in patients' care plans that some patients moved to the Allis unit lacked capacity and would have been unable to consent to the move. We also saw no record of discussions with patients with capacity in relation to the move and no capacity assessments or best interest discussions for those without capacity. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

Another relative described there not being a system on the Allis unit and described difficulty at gaining access to the unit. They described their concerns with medicine administration when on the unit, particularly as timing affects the medications' effectiveness. One carer agreed they had a concern over an access fob being left in their relative's room as the patient managed to leave the unit on a previous occasion. We saw no incident report form for the fob found in the patient's room.

One carer told us that the move to Allis unit had 'knocked their confidence' in the provider.

One relative described the Retreat York as caring and supportive, but they did wonder about the suitability of Allis unit for elderly gentlemen. Another described the staff as wonderful. We found that families had concerns regarding the Allis unit and did not find that the provider prioritised the patients' dignity in terms of the move.

Families also said that the provider had since kept them informed of all developments into the safeguarding investigation.

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

Inadequate

Leadership, morale and staff engagement

Staff told us that they knew how to use the whistle-blowing process. The safeguarding alerts relating to Allis and George Jepson units were raised by two members of staff; this resulted in the safeguarding team and leadership team sharing the concerns with the Care Quality Commission, commissioners, local authority and police. However, other staff who visited the Allis unit did not raise concerns about its suitability. Staff whistleblowing and feeling able to raise concerns internally had been a concern at other inspections.

Staff we spoke to felt able to raise concerns without fear of victimisation, however one staff member described the move to Allis as a 'done deal' and therefore saw no point to raise any concerns. Another member of staff told us they had raised their concerns around Allis unit to the unit manager but were told that the senior leadership team had approved the move; so they did not escalate their concerns further.

One member of staff described an occasion where they had raised an issue relating to staff bullying on George Jepson unit and the unit manager had discretely resolved the problem. Staff also told us that they were able to approach

the senior leadership team and felt confident that matters would be resolved but that information wasn't communicated back to them. Staff also told us that there was not a lot of oversight and discipline on the unit; they described agency staff on the rota arriving late to work and there being no repercussions. One member of staff described morale on the unit as weary but all staff described their close working relationships and enjoyment of their roles. They described the stress they felt in terms of working on the unit; however the majority did not feel that staffing impacted on patient safety.

Communication and planning of the George Jepson flooring refurbishment

We asked the provider how the plan to move patients was communicated to staff. The provider told us that they could find no formal communication plan but that staff had been advised by the unit manager verbally. When we spoke with staff they told us that knew of the move but were assigned to Allis unit or George Jepson when they arrived on shift. There was no rota in place to differentiate staffing on the units and insufficient staff to maintain patient safety at all times. Initially, when the alerts were raised, the chief executive told the Care Quality Commission that the move to Allis was scheduled to be for two or three days. A plan of works from the maintenance team showed that patients were to be moved for six weeks. We saw no oversight of the senior leadership team in terms of the move and found the senior leadership including the chief executive, were not fully informed. There were significant issues that threatened the delivery of safe and effective care and these were not identified. We found there to be a lack of clarity about who had the authority to make decisions in regards to the move. The provider told us that there was no sign off of works at the leadership team meeting or at the board meeting. We requested meeting minutes as evidence of discussion but these were not submitted by the provider. The Retreat provided a copy of the capital purchase approval form signed by the chief executive for the costs associated the George Jepson flooring works. They also provided email content showing a response from a member of the senior leadership team to a request made by the chief executive that explained the rationale for the use of Allis during the work. The document included an overview of the cost of making Allis useable.

The provider also told us that they could not evidence any environmental risk assessment for either George Jepson or Allis units in advance or during the flooring work. The unit manager stated that they had completed environmental risk assessments and had left them in a folder on Allis unit. At the time of writing the provider had not been able to locate this information. The provider commented that it did not appear that any environmental risk assessments were done for either Allis Unit or George Jepson prior to the work commencing on George Jepson. We reviewed 12 care plans and found no evidence that patients had received individualised risk assessments in relation to the flooring work on George Jepson unit or move to Allis.

We asked the provider about their decision making regarding which patients were best placed to move from George Jepson unit to the Allis unit. The provider told us that this decision was based on the location of the patient's room on George Jepson unit. I.e. those closest to the door. We reviewed 12 patient records saw no evidence that the provider had considered the specific clinical needs of the patients prior to the move. Patients on both George Jepson and Allis units had physical health problems that were not considered in advance of the flooring refurbishment. We were told by one member of the nursing staff that there was no grab bag available on Allis unit and not always availability of nursing staff. The provider told us that a grab bag was available on another unit. We requested multidisciplinary team meeting minutes to review for evidence of discussion but the Retreat York could not provide documented evidence of a multidisciplinary discussion around suitability of patients to move or the impact on the patients that remained on the George Jepson unit.

The provider shared an action plan associated with the flooring; this referred to patients having personal fire evacuation plans in place. We were told that personal evacuation plans had been completed and they were stored in a folder on Allis unit. At the time of writing the provider was unable to locate this information. The unit manager confirmed that there were no fire evacuation drills. The risk register had a historic item relating to Allis unit when it had previously been used as an inpatient ward. This stated that the unit was situated on the second floor of the building and there were patients who had difficulty mobilising. It said it would be difficult to evacuate these patients to a place of safety in the event of a fire on the unit. We see no reason why this was still not the case based on the patient population relocated to Allis unit.

ANNEX 3

Inadequate

Wards for older people with mental health problems

Carers told the Retreat York that they had not been properly informed of the move and they had concerns over the Allis unit's suitability for the patient group. The provider told us that the unit manager stated that the move was discussed in carers meetings and that carers were advised as and when they came into the unit during the week of the move. The Retreat York has an involvement lead who liaises with patients; we saw no evidence of their involvement in engaging with relatives.

We asked the provider for evidence of deep cleaning activity and subsequent cleaning in line with infection control best practice. The provider told us that staff were routinely trained in infection control and that they would know the appropriate practice. At the last inspection in November 2016 all staff on George Jepson unit had completed infection control training within the past three years; this was the target as set by the provider. We saw that the George Jepson unit was clean during our inspection. However at the time of our inspection, following the patients return to George Jepson unit we observed Allis unit to be dirty and saw evidence of a lack of proper planning in the cleaning communication book and unit manager's action plan. The cleaners were understaffed at the time of the move and one member of staff cleaned the unit for three hours prior to the patients relocating to the unit. We saw that the cleaning staff did not have the capacity to offer anything more than a basic service when patients were on the unit.

The unit manager's plan highlighted that a staffing review was to be conducted after the first week of the move to Allis unit. The provider told us that a staffing review was conducted and verbally agreed between the unit manager, deputy unit manager and director of operations who was a member of the senior leadership team. They told us that the unit manager had said that staffing had been increased but that they could see no evidence of this in staff timesheets or off duty sheets. We reviewed handover notes for the period the patients were on Allis and saw that staffing had increased, one additional member of staff was allocated to the late shift. We also saw that there was not always a qualified nurse on both units at all times.

The safeguarding alerts received emphasised a lack of personal care and fluid intake for patients for both units when patients had been moved to Allis unit. We saw on patients' activity notes that fluids were being recorded and volume varied. We saw that personal care was being recorded, however patients activity notes also recorded that patients were urinary and faecal incontinent on a regular basis. The provider told us that they had been unable to find evidence confirming fluid intake and personal care completion on the electronic record system at the time of writing.

We queried in what way patients were orientated to Allis unit prior to the move and what activities were available for patients while on the unit. The unit manager told the provider that patients had been shown regularly around Allis in advance of the move and it would be recorded on the electronic record system. We were unable to locate this information in the patients' care records and the provider also confirmed that they were unable to find this information. We did see in the activity notes that staff from the multidisciplinary team visited Allis units when patients were on the unit and we saw evidence of patient outings to the Quaker pantry and other therapeutic groups being held on and off the unit; we did not find activities were recorded every day for all patients.

The chief executive confirmed that the areas found lacking were to be managed further under the Retreat York's disciplinary procedures.

Following the inspection on 13 February 2017, The Retreat York agreed to a request made by the CQC on 30 March 2017 not to use Allis unit without prior consultation and a visit from the CQC.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care and treatment is provided in a safe way for patients.
- The provider must ensure that risks to the health and safety of patients receiving the care or treatment are assessed and mitigated.
- The provider must ensure that all premises are clean and safe with suitable equipment and facilities.
- The provider must ensure that patient dignity and respect are considered and acted in accordance with at all times.
- The provider must ensure that all patient documentation is complete and filed appropriately on the George Jepson unit.
- The provider must ensure that all safeguarding incidents are reported.
- The provider must ensure that appropriate planning and governance processes are in place; this includes ensuring that environmental and patient risks are identified, captured, managed and communicated with patients, families and staff when making decisions that affect the service.

Action the provider SHOULD take to improve

- The provider should ensure patients have access to outside space and all facilities available on the unit.
- The provider should ensure that agency staff understand patients' needs and the unit environment.
- The provider should ensure all patients risk documentation is updated according to their own policy.
- The provider should review restrictive practices such as locked doors and ensure these are assessed on an individual basis.
- The provider should ensure staff have protective equipment for cleaning and serving food.
- The provider should ensure that there is a hoist available for patients on George Jepson unit.
- The provider should ensure there are appropriate staffing levels and skill mix to ensure staff can spend meaningful time with patients and observe patients at all times. Staffing levels and skill mix should be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.
- The provider should ensure that food stored in fridges is labelled appropriately.
- The provider should ensure that patients are wearing safe footwear in line with patient care plans.
- The provider should ensure they engage in a timely way with patients and relatives regarding changes to care and treatment which may impact on the patients' wellbeing.

ANNEX 3

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 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not ensure that:** Each person's privacy must be maintained at all times including when they are asleep, unconscious or lack capacity. **How the regulation was not being met:** One patient on George Jepson unit had been moved to a room that was not personalised and did not offer the patient privacy; there was no privacy film on the door panel or windows. Patient belongings were stored in a basket on the floor in the room. This was a breach of 10(2)(a).

ANNEX 3

This section is primarily information for the provider

Enforcement actions

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not ensure that:** Systems and processes were established and operated effectively to prevent abuse of service users. **How the regulation was not being met:** Staff did not report safeguarding concerns for patients on Allis unit; this included nurses, support workers, psychologists, dietician, physiotherapy and the chaplain. One member of staff descried the move as a 'done deal' and another told us that they had raised concerns with the manager. This was a breach of 13(2).