Oak Tree Forest Limited

Ellern Mede Derby

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The service had a clear and detailed treatment model in place but staff did not complete appropriate, regular physical health checks and document detailed treatment plans in line clinical guidance and the service model.
- The service had high healthcare assistant vacancy rates and a reliance on temporary agency staff.
- Staff did not complete post incident checks, including neurological observations of young people and body maps when young people had sustained injuries.
- The service did not always complete patient searches and log these in line with the service policy after a young person had taken leave, increasing the risk of items being secreted onto the ward area.
- Care planning documentation did not always give a detailed rationale around the treatment plan prescribed for young people, particularly around physical health needs and mental state for young people who were at a healthy weight for their height.
- Young people did not have adequate storage for their belongings and staff did not manage items of potential risk safely, increasing the risk of young people's belongings being lost or a potential safety incident occurring.
- Governance processes did not always ensure that ward procedures ran smoothly. The processes in place did not always identify gaps in post incident checks, gaps in young people's physical health checks and gaps in young people's care planning.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors to keep people safe.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- The service delivered tailored training specific to the service.
- Staff felt listened to and able to influence service delivery. Staff spoke positively about the service and were proud of their work and enjoyed their role.
- The service provided psychological therapies in line with national guidance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Requires Improvement 	Our rating of this location went down. We rated it as requires improvement because: • The service had a clear and detailed treatment model in place but staff did not complete appropriate, regular physical health checks and document detailed treatment plans in line clinical guidance and the service model. • The service had high healthcare assistant vacancy rates and a reliance on temporary agency staff. • Staff did not complete post incident checks, including neurological observations of young people and body maps when young people had sustained injuries. • The service did not always complete patient searches and log these in line with the service policy after a young person had taken leave, increasing the risk of items being secreted onto the ward area. • Care planning documentation did not always give a detailed rationale around the treatment plan prescribed for young people, particularly around physical health needs and mental state for young people who were at a healthy weight for their height. • Young people did not have adequate storage for their belongings and staff did not manage items of potential risk safely, increasing the risk of young people's belongings being lost or a potential safety incident occurring. • Governance processes did not always ensure that ward procedures ran smoothly. The processes in place did not always identify gaps in post incident checks, gaps in young people's physical health checks and gaps in young people's care planning. However: • The ward environments were safe and clean. The wards had enough nurses and doctors to keep people safe.

Summary of findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- The service delivered tailored training specific to the service.
- Staff felt listened to and able to influence service delivery. Staff spoke positively about the service and were proud of their work and enjoyed their role.
- The service provided psychological therapies in line with national guidance.

Summary of findings

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Summary of this inspection

Background to Ellern Mede Derby

The hospital opened in July 2022 and had its first comprehensive inspection as part of our ongoing monitoring and inspection of registered services in February 2023, where the service was rated as good overall. This inspection was a focussed, unannounced inspection of the service following information of concern around patient safety.

Ellern Mede Derby is a hospital run by Oak Tree Forest Limited. The service provides inpatient services for children and young people with eating disorders aged 8 to 25 years. The hospital is for children and young people of all genders. The hospital offers 17 inpatient beds across two units; Derwent ward and Trent ward. Derwent ward is on the first floor for young people aged 8 to 18 years. Trent ward is on the ground floor is currently closed as part of the services gradual opening and is planned to be for 18 to 25 year olds. At the time of inspection, there were 6 young people aged between 11 and 17 years admitted to Derwent ward. The hospital has an onsite school to provide children and young people with an education during their admission.

The hospital did not have a manager registered with the CQC in post at the time of the inspection but was being supported by the provider's clinical operations director and special projects director, with the newly appointed manager due to start in January 2024.

The hospital is registered by the CQC to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983.

• Diagnostic and screening procedures

• Treatment of disease, disorder, or injury.

The main service provided by this hospital is specialist eating disorder service for children and adolescent mental health services.

At this inspection we did not inspect all areas of the key questions because this was focussed on specific areas of concern. We inspected against the key questions of safe, effective, responsive and well led. We re-rated the service as requires improvement.

What people who use the service say

There were 6 young people using the service when we inspected. We spoke to 2 young people using the service and 6 family members and carers.

Both young people knew what items were restricted on the ward area and why and been involved in their individual risk assessments for this. Both young people felt there were not enough activities at the weekends. They felt some staff treated them well but other did not and they had raised complaints, but they had not been responded to. They knew how to access an advocate as they visited the ward every week.

We spoke to 6 family members. Five felt the permanent staff were good and caring. Three family members felt training for agency staff was an area of improvement the service needed to address.

Summary of this inspection

Four felt they were kept informed and were actively involved in care and treatment, but 2 family members did not feel listened to or involved in their child's care and treatment.

All family members were aware of restraints, but one was concerned about the restraint due to their child telling them they were hurt, and one felt their child was unfairly restrained when they were nasogastric tube fed.

Two family members felt the family visit room and facilities could be improved, particularly for those that are visiting from a long distance.

How we carried out this inspection

During our inspection on 7 and 8 November 2023, we:

- observed how staff cared for young people
- spoke with 2 young people who were using the services
- spoke with 12 staff including a nurse, nursing assistants, clinical psychiatrist, family therapist, dietician, lead clinician, medical director and social worker
- looked at the quality of the ward environment
- reviewed 4 young people's records
- reviewed 6 young people's prescription charts
- reviewed 11 incident records
- reviewed a range of policies, procedures and other documents relating to the running of the services.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that staff complete searches in line with the service policy after young people have completed Section 17 leave (Regulation 12).
- The service must ensure young people's physical health checks are completed and recorded in line with the service policy and national guidelines (Regulation 12).
- The service must ensure they complete post incident checks including neurological observations after incidents involving head banging and body maps after injuries have been sustained (Regulation 12).
- The service must ensure staff manage items of risk on the ward which may present a potential risk to young people. (Regulation 12)
- The service must ensure all young people have sufficient safe and secure storage for their possessions (Regulation 15).

Summary of this inspection

- The service must ensure appropriate audit systems are in place to identify if post incident checks including body maps are completed after injuries are sustained and appropriate neurological and physical health checks are completed after incidents. (Regulation 17)
- The service must ensure appropriate audit systems are in place to identify gaps in post leave search documentation. (Regulation 17)
- The service must ensure appropriate audit systems are in place to identify if all young people's care plans include a personalised and clear narrative around the rationale for a treatment plan. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure that all medical equipment is kept in stock.
- The service should ensure medicines records include a young person's photo.
- The service should ensure young people's Section 17 leave is not impacted on by the lack of number of staff being able to drive the service vehicle.
- The service should ensure the incident policy in place guides staff around completing post incident checks after incidents.
- The service should ensure issues raised through young people's feedback are addressed or appropriate feedback is given.
- The service should ensure body maps state how injuries have been sustained.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires Improvement	Requires Improvement	Inspected but not rated	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Inspected but not rated	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Specialist eating disorder services

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Inspected but not rated
Responsive	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The service carried out regular ligature risk assessments, infection control audits and environmental audits.

Staff could observe children and young people in all parts of the wards. All young people on the ward at the time of the inspection were supported with daily enhanced observations. The service had closed circuit television camera monitoring and had placed curved mirrors around the ward to help mitigate blind spots.

The ward complied with guidance and there was no mixed sex accommodation. All young people at the service were female and all bedrooms on the ward were en-suite rooms. The service was able to accommodate a male young person if they were admitted. If the room was not en-suite the bathroom closest to the male young person's bedroom would become a male only bathroom.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The service had a detailed ligature risk assessment in place that was reviewed annually. The risk assessment detailed each risk in the specific ward areas and mitigation in place, whether this be through individual risk observations or the use of closed-circuit television or curved mirrors.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. The service had nurse call bells within all rooms and zones for communal areas. If the alarm was pressed staff responding to the emergency would know which zone assistance was required.

Maintenance, cleanliness and infection control

The ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records and found they were up to date. We saw housekeeping staff cleaning the premises during the inspection.

Staff followed infection control policy, including handwashing. The service had hand sanitiser available throughout the premises and we saw posters around the ward promoting effective hand washing. The service completed monthly infection control and prevention audits, which looked at a wide range of processes and equipment including availability of personal protective equipment, staff training and cleaning plans. No concerns had been raised through these in the last 6 months.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We found the clinic room was secure when not in use and medicine was stored securely and safely. The clinic room was clean and tidy, and the medicine stock was maintained. We reviewed the clinic room cleaning records and found they were up to date. Emergency equipment was checked regularly by staff and the pharmacy visited regularly to check medicine management.

Staff checked, maintained, and cleaned equipment. Staff had access to most medical equipment, including thermometers, scales and blood pressure monitors, which had all been checked regularly. However, we found the service had run out of urinalysis sticks. This could delay urine tests and therefore delay medical treatment. When we raised this with the service, they told us they had ordered these and they would usually send samples to a lab for a thorough analysis but agreed these should not have been out of stock.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received appropriate training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe on each shift. During the day the service had a minimum of 2 nurses and 4 healthcare assistants on shift and at night they had a minimum of 1 nurse and 3 healthcare assistants on shift. The service was able to increase the number of healthcare assistants depending on the level of enhanced observations required. The service used a mixture of permanent and agency or bank staff on each shift but always ensured there were some permanent staff on each shift.

The service had a high vacancy rate. The service had 2 qualified nurse vacancies and 25 nursing assistant vacancies, which was a vacancy rate of 18% and 47% respectively. Managers told us they were continuing with a recruitment drive.

The service had high rates of bank and agency nurses and nursing assistants. The service used bank or agency daily, but these staff were always supported by permanent staff. The service used a high number of agency staff during the night shifts. Within a 28 day period between October and November 2023 on 27 days the nurse on duty at night was a bank or agency staff member.

Managers requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had a cohort of agency staff that were familiar with the service and the young people at the service and aimed to always use these. All agency and bank staff had received a service specific induction and training programme before they worked a shift on the ward. All nurses that completed nasogastric tube feeds had specialist training and competency checks in place.

The service had a varied staff turnover rate. The staff turnover rate varied from 4% to 8.5% over the last 6 months with the highest turnover rate in August where it was 8.5% and this had reduced to 4% in October.

The service had 10 to 15 episodes of staff sickness per month over the last 6 months. The highest sickness rate was 15 episodes in June 2023, July 2023 and October 2023, which had lowered to 11 episodes in November 2023. Managers supported staff who needed time off for ill health. Staff we spoke with told us management were supportive.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers reviewed required staffing levels daily and the morning “flash meetings” as this depended upon young people’s need. Managers were able to request agency and bank support as required. All staff we spoke to told us staffing levels were always safe. One staff member told us staffing could be stretched if incidents occurred whilst a young person was being supported for a nasogastric tube feed, but the staffing was not unsafe.

Children and young people had regular one to one sessions with their named nurse. There were only 6 young people at the service, and all received one-one time with their named nurse.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Although leave was never cancelled due to staffing levels. We found young people who were only granted leave in a car could not always access this due to a shortage of staff that were insured to drive the service’s vehicles. The service told us they were looking to increase the number of staff insured on the service vehicle. One family member told us the lack of drivers impacted on their child’s ability to access Section 17 leave.

Staff shared key information to keep children and young people safe when handing over their care to others. Handovers included a discussion on incidents, observations and support required by each young person.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The service had 2 doctors and a lead clinician for the site and a medical director that oversaw clinical practice and visited the service every 2 weeks. The service had an on-call system in place for out of hours medical cover.

Managers could call medics from sister services when they needed additional medical cover. The closest sister service was an hour away in Rotherham.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. Staff training data for November 2023 showed mandatory training compliance rate of over 90% for all mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The service provided service specific training for all staff including service specific physical intervention training and meal support training.

The physical intervention training was given to all agency and bank staff before they started a shift at the service. All permanent staff had completed meal support training. All agency and bank support staff had either completed or signed up to complete the meal support training. Staff told us this was tailored training delivered by the organisation's dietetics team around the support they should provide to young people during mealtimes.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a training manager to oversee and alert staff of their training compliance and training needs.

Assessing and managing risk to children and young people and staff

Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, staff did not assess and manage risks to children, young people and themselves well.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 4 young people's records and found risk assessments in place. These had been reviewed weekly by a multidisciplinary team and if required after every incident. Each young person had individualised "patient friendly" plans in place that had been developed by the young person highlighting their risks and how staff should support them.

Staff used a recognised risk assessment tool, however, these were not detailed. The risk assessments were not detailed for all areas of care. All young people on the ward were at risk of malnutrition but there was no clear guidance around when staff would intervene to feed a young person via a nasogastric tube using restraint when they were at their target weight for height. There was no clear guidance around physical health checks or triggers that would lead to this intervention. The National Institute for Health and Care Excellence guidance states when assessing for an eating disorder physical signs of malnutrition including poor circulation, dizziness, palpitations, fainting or pallor should be considered. Medical Emergencies in Eating Disorders Guidelines also states physical health checks should be completed regularly. However, the service was not completing physical health checks regularly and personalised physical health results were not being considered within young people's risk assessments for those who had reached their target weight for height before they received nasogastric tube feeding under restraint. After the inspection the service provided us with assurance that physical health checks were now being prescribed and reviewed daily at the morning multidisciplinary meetings and these were now being incorporated into individual care plans.

Management of patient risk

Staff knew about risks to each child and young person and acted to prevent or reduce risks. All permanent staff had access to the electronic record system which gave them guidance on how to support the young person. Agency nurses were also given a temporary login to the record system, computer logins and email access, whilst at the service. Agency support staff told us that although they did not have access to the electronic recording system, they attended a detailed handover and were given a paper copy of young people's care plans and risk assessments with observation charts. The service managed the risk of refeeding syndrome through dietetic assessments on admission and planning of meals and food intake daily through the morning meetings and weekly at ward round meetings. (Refeeding is the process of reintroducing food after malnourishment or starvation. Refeeding syndrome is a serious and potentially fatal condition that can occur during refeeding. It's caused by sudden shifts in the electrolytes that help your body metabolize food.)

Staff identified and responded to any changes in risks to, or posed by, children and young people. We observed a morning flash meeting where a staff from the ward and members of the multidisciplinary team attended to discuss the last 24 hours. Incidents, staffing, additional support for young people, observation levels and arrangements for Section 17 leave were discussed at this meeting.

Staff did not always follow the service's policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. The service had a search policy in place guiding staff to complete a young person search returning from hospital leave. We reviewed 7 young people's Section 17 leave (Section 17 of the Mental Health Act 1983 allows for certain young people who are detained under the Mental Health Act to be granted 'leave of absence' from the hospital in which they are detained for a specified or indefinite period subject to particular conditions specified in their leave care plan) records and found on 3 occasions staff had failed to complete the post leave search record. This increased the risk of young people bringing risky items onto the ward area that could lead to patient safety incidents. After the inspection staff provided us with assurances that they had been reminded of the search protocol in place and managers were now auditing and monitoring if these checks and records had been completed.

The system in place for the management of restricted items was not robust. Young people could store their items of risk securely in 3 different locations including in a locked drawer under their bed, a locked communal cupboard or in a spare bedroom. Logs were in place to sign items in and out but had not been used by staff. This increased the risk of potential items of risk not being returned or going missing and leading to potential safety incidents. After the inspection managers provided us with assurances that each young person had a restricted items log in place and these were now being monitored.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme. During an incident review we saw staff always used verbal de-escalation or distraction techniques before restraint was used to keep young people safe.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Within the records we reviewed we saw young people had been involved in writing personalised de-escalation techniques staff could use to support them when their behaviours or anxieties were increasing.

However, not all aspects of the service's restrictive interventions reduction programme met best practice standards. The service treatment model allowed staff to administer nasogastric tube feeds under restraint even when the young person was at an appropriate weight for their height. This according to the treatment model would only be prescribed under specific circumstances in which a young person who is detained under the Mental Health Act section continues to require this form of treatment to protect them and their mental and physical health from deteriorating. Members of the multidisciplinary team including the lead dietician, medical director and clinical lead told us the service model was not just around weight restoration but also around weight maintenance. Three young people were at a healthy weight for height and were nasogastric tube fed a total of 268 times under restraint in the last 2 months. This was for a range of reasons including young people who were unable to eat or drink voluntarily due to severe anorexia nervosa, not consuming enough to maintain a healthy weight or choosing to have a combination of intake including being nasogastric fed at night under close supervision. However, risk assessments and plans in place did not clearly give an individualised reason for the treatment plan in place. One of the family members we spoke to felt their child was unfairly restrained for a nasogastric tube feed and the reason given was for weight loss, but this individual was at the correct weight for her height. As the service had gaps in their physical health recordings the evidence to support the decision to

provide nasogastric tube feeds under restraint was not available. The service was not monitoring physical health or recording clear reasoning for continuing to nasogastric tube feed under restraint when the young person reached their target weight. This may have been because they were refusing all fluids which would put them at very high risk of rapid physical deterioration and death regardless of weight. Without this information the service did not have the right to restrain the young people under the National Institute for Health and Care Excellence guidance or section 63 of the Mental Health Act 1983. We raised this with the service, and they provided us with assurances that each individual's medical history was considered when a treatment plan was created, and this was discussed at the morning flash meetings. They agreed the services recording procedures needed to be improved and include a clear individualised narrative and rationale for treatment and interventions in place. After the inspection, the service provided us with assurances that all care plans were being reviewed to include this detail.

There were many restricted or prohibited items on the ward. But there was no list for this within the communal ward area. Staff told us a copy of these items was given within the young person's welcome pack. However, once we raised this with staff on the ward area, they immediately put a sign in place displaying a list of the restricted items. The two young people we spoke to knew what the restricted items on the ward were and why these were restricted.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a social worker in post who led on safeguarding and communication with the local authority.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were trained to a level 3 in safeguarding children and vulnerable adults.

Staff kept up-to-date with their safeguarding training. Safeguarding training compliance rate was at 100%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service had a safeguarding team in place, consisting of a social worker and other multidisciplinary members.

Staff followed clear procedures to keep children visiting the ward safe. The service had a dedicated family room for visitors. But 2 of the 6 family members we spoke to felt the family visit room and facilities could be improved, as there was only one family room, particularly for those that are visiting form a long distance. However, the service told us there were other rooms that could be used for family visits.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff on the ward had access to a safeguarding form and knew how to raise a safeguarding concern with the local authority. All the young people at the service were from out of the county and the service had links with each of the relevant funding authorities and kept them involved in the young people's care and treatment through regular care programme approach (a care programme approach is there to support a person's recovery from mental illness. It is a framework used to assess a person's needs and make sure that they have support for their needs) meeting.

Managers took part in serious case reviews and made changes based on the outcomes. We saw evidence of changes in practice following incidents that had been reported. The service had incidents reported of nighttime staff sleeping when completing young people's observations. Although the allegations could not be upheld, in response to the concerns the service increased the night nurse duties to carry out spot checks and all staff on the night shift were now asked to sign and confirm they had not worked elsewhere before coming on the ward to complete a night shift.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All staff had access to comprehensive patient care plans.

The service used a combination of electronic and paper records to record certain medical checks. This meant at times it was difficult to establish whether certain checks including physical health checks had been completed. The service policy guided staff to complete physical health checks for young people regularly. However, when we reviewed 2 young people's physical health check records, we found gaps. Both young people had gaps in October and November, 1 of which did not have any logs for October 2023. The service was not following national Medical Emergencies in Eating Disorders guidance as this advised young people's physical health checks should be monitored. This increased the risk of a young person's deterioration in physical health not being identified. The service told us this was mitigated partially as all young people currently at the service were on 1:1 or 2:1 continuous observation but recognised these should have been completed to meet the needs of young people as their need for enhanced observations decreased.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. But staff did not regularly review the effects of medicine on each child or young person's physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed 6 young people's medicines records and found medicine was being prescribed and administered and recorded correctly. However, the medicine recording system did not include the young people's photo which increased the risk of agency nurse administering medicine to the wrong young person. Staff told us this was mitigated as there would always be a permanent member of staff on shift but agreed this should be in place. After the inspection, the service told us they had asked young people if they could include photos on their medicines records and 3 young people agreed to have these taken.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. Young people regularly attended their ward rounds where they were involved in the treatment plan and medicine. We attended and observed a multidisciplinary ward round meeting and found young people were taking part in conversations about their treatment plan and goals.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicine was stored correctly within manufacturers guidelines and staff checked medicine storage temperatures daily to ensure they were within the recommended range.

Staff followed current national practice to check patients had the correct medicines. The service completed regular medicines audits and the pharmacists also completed quarterly medicines checks. Records showed each young person had their medicines reviewed on a weekly basis at a multidisciplinary ward round.

Staff did not review the effects of each child or young person's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Records showed gaps in physical health records. We found 2 young people did not have any National Paediatric Early Warning Scores (National Paediatric Early Warning Score or PEWS will allow for consistency in how deterioration in children is recognised). This increased the risk of deterioration in young people's physical health not being identified in a timely manner and a possible delay in medical treatment. The service had run out of urinalysis sticks and therefore at the time of the inspection was not completing urine tests. (Electrolytes such as sodium, potassium, chloride, magnesium, phosphate as well as glucose can be measured in urine. Individuals with an eating disorder are at an increased risk of electrolyte imbalance). When we raised this with the service, they told us they usually send samples to a lab for analysis and they used blood tests to measure most physical health checks, but agreed these should not have been out of stock.

Track record on safety

Reporting incidents and learning from when things go wrong.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff recognised incidents and reported them but did not always complete post incident checks appropriately.

Staff knew what incidents to report and how to report them. All permanent staff had access to the services incident reporting forms. Bank and agency staff had access to a written form that they could complete to be added to the electronic reporting system. There had not been any incidents which had met the threshold of a serious incident in the last 6 months.

Staff did not raise concerns and reported incidents and near misses in line with service policy. Staff did not always complete body maps after incidents and restraint. Staff did not complete body maps after injuries had been sustained following an incident. We reviewed an incident where a young person had sustained an injury after an incident where they had head banged but the staff did not complete a body map showing this injury until 3 days after the incident. This would make it difficult to establish if a wound was healing effectively, if further injuries had been sustained due to other incidents or if the young person required further medical attention. The service incident reporting policy in place guided staff to update the young person's risk plans after incidents and log injuries sustained. However, the policy did not guide staff to complete post incident checks including physical health checks and neurological observations where required. After the inspection the service provided us with assurances that all post incident checks were being reviewed at the morning multidisciplinary meeting.

Staff completed a weekly body map for every young person, however, these did not always give a clear explanation of how injuries had been sustained. We looked at 2 young people's body maps, one of which clearly stated a head injury that had been caused by an incident involving head banging but another showed multiple bruises with no explanation of how these had been sustained. When we raised this with staff, they were able to explain how these had been sustained.

On another incident involving restraint a young person complained of discomfort during a restraint and staff failed to complete a body map after this incident. In addition, as this incident took place during a nasogastric tube feed under

restraint the incident was reported as a nasogastric tube feed incident and not as a patient injury during restraint incident. This increased the risk of injuries during restraint not being identified and possible disproportionate restraints not being identified. After the inspection the service provided us with assurances that all post incident checks including body maps were being reviewed at the morning multidisciplinary meeting.

Staff did not always complete neurological observations (neurological observations are a collection of information on the function and integrity of a patient's central nervous system-the brain and spinal cord) after incidents involving head injuries. We reviewed 7 incidents where young people had banged their heads, but staff had not completed neurological observations to monitor the young person's health. This would make it difficult to establish the impact of the head injury and determine if the young person required further medical attention. After the inspection the service provided us with assurances that all post incident checks including neurological observations were being reviewed at the morning multidisciplinary meeting.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. Families were informed of incidents when they happened, and all incidents were reviewed by a multidisciplinary team daily. Families we spoke with told us they were informed of incidents when they occurred.

Managers debriefed and supported staff after any serious incident. We reviewed incident records and found staff and young people were always offered a debrief after incidents had occurred.

Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service. Following a recent incident of reports of night staff sleeping during young people's observations the service had introduced additional checks and processes across the Ellern Mede group.

Staff met to discuss the feedback and look at improvements to patient care. The service had a full multidisciplinary meeting every morning, weekly multidisciplinary ward rounds and each discipline also had their own meetings to discuss each young person's care and treatment. The discipline specific meetings were national meetings where good practice was shared.

Managers shared learning with their staff about never events that happened elsewhere. The service had a lessons learned board on display showing incidents from the organisation and lessons learnt implemented nationally.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. However, staff did not always follow service policy on monitoring physical health. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Requires Improvement

Specialist eating disorder services

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. We reviewed 4 young people's care records and all had a mental health assessment in place. Each young person also had an individual monthly mental capacity assessment completed with the onsite clinical lead.

Children and young people had their physical health assessed soon after admission, but these were not regularly reviewed during their time on the ward. The service policy was to monitor young people's physical health on a daily basis but we found staff did not always complete these.

Staff did not always develop a comprehensive care plan for each child or young person that met their mental and physical health needs. We reviewed 4 young people's care pans and found 3 out of 4 of these were robust and clearly showed the young person had been involved in developing these or had been given the opportunity to be involved in these. Most young people had a "patient friendly" care plan in place that they had written. This informed staff of how they would like to be supported. However, one of the care plans was not personalised and did not include their specific physical and mental health needs and how this related to their treatment plan. The plan did not show clear links to the services treatment model and did not include a clear narrative around the rationale for a treatment plan prescribed. Personalising care plans was an area of improvement identified within the last inspection, that the service was still working towards.

Staff regularly reviewed and updated care plans when children and young people's needs changed. Every young person had a weekly ward round where their care plans and treatment goals were reviewed. These meetings were attended by the young person and a full range of multidisciplinary team members including medics, ward staff, therapists, and a dietician. These plans were reviewed weekly or as required if incidents occurred.

Most areas of care plans were personalised, holistic and recovery orientated. Each care plan had specific individualised treatment goals in place, which were reviewed regularly.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives, but did not always complete physical health checks regularly. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service. Young people had access to one to one therapy, family therapy, group therapy, school and tailored activities. We saw records of all young people having one to one time with their named staff nurse. The activity co-ordinator developed personalised activity programmes in consultation with the young people and multidisciplinary team.

Staff did not always deliver care in line with best practice and national guidance. Staff identified children and young people's physical health needs but did not always record them in their care plans. Physical health records showed staff carried out vital signs monitoring young people. These included blood pressure, temperature and oxygen saturation levels. The service had a physical examination suite available on site. However, there were gaps in these records showing checks had not been carried out regularly. The National Institute for Health and Care Excellence guidance states when assessing for an eating disorder physical signs of malnutrition should be considered.

Requires Improvement

Specialist eating disorder services

Staff met children and young people's dietary needs, and assessed those needing specialist care for nutrition and hydration. We saw young people's personalised mealtime plans. Some young people were eating regular oral meals, others had nasogastric feeding, and some were on a mixed oral and nasogastric feeding plan.

The service required staff to have a yearly nasogastric feeding competency test, which assessed staff's administration techniques. This competency test was also carried out following any concerns raised, such as after an incident.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. The service care pathways guided staff completed Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS) on admission and then every 3 months until discharge to monitor young people's progress, symptoms and wellbeing. Outcome measures were also used within individual meetings with young people to review care and treatment plans; these were reviewed weekly within ward rounds.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. At the time of the inspection the service was in the process of carrying out its own internal audit, being conducted by a service manager of a sister service.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the children and young people on the ward. The service had a full multidisciplinary team in place at the service including, a psychologist, assistant psychologist, occupational therapist, doctors, dietician, family therapist and activities coordinator.

Managers supported staff through regular, constructive appraisals of their work. Every permanent member of staff had received an annual appraisal with the compliance rate being 100%.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Most permanent members of staff had a monthly supervision with compliance rates at 85%, this was due to some staff being on long term sick.

Managers made sure staff received any specialist training for their role. The service had developed meal support training, autism and eating disorders training specific to the service. Managers told us the service had young people with a high level of acuity and they aimed to deliver specific training to staff to support them. Agency staff told us they were given a thorough service induction prior to starting a shift including details of risks on the ward area and individual risks.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. The multidisciplinary team met daily to discuss each young person and immediate changes in the last 24 hours. They also had weekly multidisciplinary ward rounds where each young person was discussed in detail and a review of short term and long-term goals were discussed.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Daily handovers included and overview of incidents, the level of observations for young people, overview of those on Section 17 leave, planned meetings and possible safeguarding incidents or complaints.

Ward teams had effective working relationships with other teams in the organisation. All staff we spoke with felt there was no hierarchy in place between ward staff and the medical staff or multidisciplinary team in place. Inspectors saw constructive conversations taking place on the ward between the service responsible clinician and activities coordinator and at ward round meetings.

Ward teams had effective working relationships with external teams and organisations. The service had young people at the service from across the United Kingdom and had developed good working relationships with all local authorities, with named contacts for each young person.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Mental Health Act training compliance for the service was at 92%.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service had a Mental Health Act administrator in post and a lead social worker to support staff as required.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. An advocacy service visited the ward weekly and gave young people the opportunity to request additional support through text and an option for them to support at meetings including ward rounds. The advocacy service told us they could approach the service with any concerns and had always received a detailed response in a timely manner.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. Each young person was made aware of their rights monthly.

Staff could not always make sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. This was not due to staffing issues but linked to the lack of staff insured to drive the service car. When we raised this with the service, they informed us they were looking to increase the number of staff insured on the car to help facilitate approved car leave.

Requires Improvement

Specialist eating disorder services

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. The service had a Mental Health Act administrator in post who ensured all detention documentation was available and renewed appropriately. All young people had appropriate detention papers in place.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of inspection, 92% of staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards and 97% of staff had completed capacity, competency and consent to treatment training.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. The service had a lead social worker at the service that staff could approach for advice.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so. Most young people attended their weekly multidisciplinary ward round meeting where they discussed their treatment plans and goals.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history. Every young person had a monthly capacity assessment in place. This was completed with the service clinician and the young person. All young people at the service were detained under the Mental Health Act at the time of the inspection.

Is the service caring?

Inspected but not rated

Our rating of caring stayed the same. The previous rating of good remained.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people kindness. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were mostly discreet, respectful, and responsive when caring for children and young people. The 2 young people we spoke with felt some staff treated them well but others did not, they felt some agency staff did not know them that well. Five family members felt the permanent staff were good and caring. We saw staff in the lounge area conversing with young people during observations and observed teachers working with young people in the school.

Staff gave children and young people help, emotional support and advice when they needed it. Both young people we spoke with knew how to access an advocate as they visited the ward every week. We saw staff interacting with young people during observations. One young person had a pet guinea pig at the service and we saw staff supporting them spend time with their pet.

Staff supported children and young people to understand and manage their own care treatment or condition. Both young people we spoke with knew what items were restricted on the ward area and why and been involved in their individual risk assessments for this.

Involvement in care

Staff involved children, young people in care planning and risk assessment. They ensured that children and young people had easy access to independent advocates. But not all family members felt actively involved in their child's care and treatment.

Involvement of children and young people

Staff involved children and young people and gave them access to their care planning and risk assessments. Staff made sure children and young people understood their care and treatment. All young people were able to attend their ward round if they chose to and discuss their treatment plan with the multidisciplinary team.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. However, the service did not respond to all feedback given. The service held weekly community meetings, where young people could give feedback on services and was able to demonstrate they had responded to feedback around a group about social media and coping with triggers, by developing this course. During an environmental audit completed in September 2023 young people raised concerns about storage and the patient cupboard being messy was leading to their belongings being lost as feedback. However, this item was not identified as an action and at the time of the inspection this was still an issue. After the inspection the service provided us with assurances that items were now being stored effectively. The 2 young people we spoke with told us they had raised concerns but had not received a response, however, they were not sure if these were formal complaints.

Staff supported children and young people to make decisions on their care. Staff supported young people to attend ward rounds and provided meal support during mealtimes.

Staff made sure children and young people could access advocacy services. The advocacy service visited the service once a week and attended the patient's community meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported and informed families or carers. But all family members did not feel they were involved in their child's care. Four felt they were kept informed and were actively involved in care and treatment, but 2 family members did not feel listened to or involved in their child's care and treatment. All family members were given the opportunity to complete a feedback form before each ward round which would be considered at the meeting, but 2 family members felt they would like to be involved in the conversation rather than being informed of decisions after the meeting had taken place.

Requires Improvement

Specialist eating disorder services

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Managers made sure bed occupancy did not go above 85%. Derwent ward was a small unit, which could accommodate 10 young people and at the time of the inspection there were 6 young people on the ward which made the occupancy levels 60%. The unit downstairs was currently empty, and the service were in the process of developing this into a young adults (aged 18 to 25) unit.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. The service had recently discharged 3 young people from the service.

The service had all out-of-area placements. All 6 young people at the service were from out of area and the service were able to demonstrate how they had developed links with the young people's local commissioning teams.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Each young person had short term and long-term goals in place to help them work towards discharge.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed. Each young person had a discharge plan in place, which was developed at the point of admission. This was reviewed at a weekly multidisciplinary ward round where goals toward discharge were assessed.

Children and young people did not have to stay in hospital when they were well enough to leave. The service considered young people's physical and mental health when planning their discharge.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. The service discussed discharge at preadmission meeting and at the first care programme assessment meeting. A young person's discharge was discussed at admission along with an expected discharge date and the service then worked towards this. This was a discussion the service had with the young person, their family and commissioners. This would then be reviewed at formulation and re formulation meetings depending on the individual progress in treatment.

Facilities that promote comfort, dignity and privacy

Requires Improvement

Specialist eating disorder services

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. There were quiet areas for privacy. Each child and young person had their own bedroom but did not have sufficient appropriate storage to keep their belongings safe.

Each or young person had their own bedroom, which they could personalise.

Children and young people did not have sufficient secure place to store personal possessions. Young people had a cupboard space where they had stored piles of clothing and belongings. One young person told us they would like more storage but hadn't raised this with the service. Young people had their items stored in 4 different areas including their bedroom cupboard (which they could access as it was open), lockable storage under their bed (which could be accessed through staff supervision), each young person had a downstairs bedroom where their additional items and a storage in a cupboard. The service held a list for each young person showing what items they had brought into hospital but there was no log of what items were kept where. No items in the communal storage cupboard had been labelled and there was no log of which bedroom had been assigned to store spare items for each young person. This increased the risk of young people's items being lost or used by other young people.

Staff used a full range of rooms and equipment to support treatment and care. The service had a separate school on site, a lounge, a multi-use area for activities, a sensory room, a dining room and therapy kitchen room known as the Bistro where young people accessed therapeutic activities. The service had a feeding room, which was next to the dining room, but the service aimed to provide nasogastric tube feeds when the dining room was not in use to ensure privacy.

The service had quiet areas and a room where children and young people could meet with visitors in private. The service had a dedicated family room where young people could meet their family members with a separate toilet area which included baby changing facilities.

Children and young people could make phone calls in private. Every young person had access to their own mobile phone that had been risk assessed by the multidisciplinary team regarding the risk around access to social media.

The service had an outside space that children and young people could access easily. The service had 2 small outdoor spaces one with seating and another outdoor space with wooden garden planters. This was adequate for the 6 young people at the hospital, but the service was looking to expand the outdoor space further.

Young people's drinks and snacks intake were monitored by staff in line with their individual meal plans, developed by the dietician.

The service offered a variety of good quality food. Young people had individual meal plans agreed under the direction of dietitian and multidisciplinary team.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Requires Improvement

Specialist eating disorder services

Staff made sure children and young people had access to opportunities for education and work, and supported them. The service had built a school on site and provided tailored education. Five of the 6 young people on site had a tailored formal educational programme in place. The service encouraged young people not attending school to gradually build this into their daily routine. Young people who were not attending education were regularly encouraged to attend school or have complete schoolwork in their room.

Staff helped children and young people to stay in contact with families and carers. Family members told us they spoke regularly to their child by phone or through pre-arranged visits to the service.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Young people used Section 17 leave to go to the local shops and into town.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had adapted bedrooms, bathrooms and a lift.

The service had information leaflets available in languages spoken by children, young people and the local community. The service did not have any young people who required information in a different language at the time of the inspection, but staff told us they could request these if required.

Managers made sure staff, children and young people could get help from interpreters or British Sign Language interpreters when needed. Although the service did not have any young people who required interpreters staff told us they could request and access these services if required.

The service provided a variety of food to meet the dietary needs of individual children and young people. Each young person had a meal plan in place that had been put together by the dietician in consultation with the multidisciplinary team and treatment plan in place.

Children and young people had access to spiritual, religious and cultural support. The hospital had a multi faith room, that young people could access.

Listening to and learning from concerns and complaints

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

Children, young people, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service had the complaints policy on display within the communal area and all young people and families knew how to raise a complaint. The service had an independent advocacy service that attended the ward weekly and supported young people to raise complaints if requested. However, 2 young people we spoke to told us they had raised complaints but not had a response, however, they were not sure if these were formal complaints and did not want to give details on the complaints raised.

Staff understood the policy on complaints and knew how to handle them. The service had a detailed complaints policy in place. The policy was on display within the ward communal area and staff knew the process of recording and responding to complaints.

Managers investigated complaints and identified themes. The service had received 4 complaints in the last 6 months. These included concerns raised by neighbours, parents and family members, whistleblowers and concerns from commissioners. The service had responded to all concerns in line with their policy and carried out investigations where required.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment. The independent advocate who attended the ward weekly told us they could raise concerns on behalf of young people and had always received a detailed response when they had raised any concerns.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. The service acknowledged all formal complaints formally within 2 days in line with their policy and responded formally within 25 working days.

Managers shared feedback from complaints with staff and learning was used to improve the service. Where required the service carried out formal investigations to ensure all concerns were investigated thoroughly. An example was when a complaint around staff sleeping during nighttime observations was raised. The service reviewed CCTV and carried out spot checks. Although the concerns could not be upheld, they service introduced new checks and provisions from lessons learnt. The service had a national lessons learnt monthly bulletin. All staff received a copy of this, and it included lessons learnt from across the organisation.

The service used compliments to learn, celebrate success and improve the quality of care. The service carried out an annual complaints analysis to help identify themes and trends in concerns raised.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff. At the time of the inspection the service did not have a registered manger in post; a new manager had been appointed and was due to start their role in the new year. The nominated individual and the provider specialist project manager were overseeing the service in the interim. All staff at the service knew who was overseeing the service and felt senior management were approachable and visible at the service. The medical director visited the service regularly and often supported the weekly ward round meetings.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Requires Improvement

Specialist eating disorder services

Staff we spoke with knew the organisation's vision and values. All staff we spoke with felt pride in the service they worked for and their vision of supporting young people regain and maintain normal lives. Staff were able to articulate the philosophy of the service. Most staff felt listened to and able to influence service delivery. Staff spoke positively about the service and were proud of their work and enjoyed their role. Agency staff members told us they felt part of the staff team.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us they felt valued and respected and there was no hierarchy between nursing staff and the multidisciplinary team. They all worked together to provide the best care for young people.

Staff knew about the freedom to speak up guardian and the whistleblowing process. The service had posters around the service informing staff and young people around how to raise concerns.

We saw examples, where staff had been supported for development and career progression.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Our findings from other key questions showed audit processes in place were not always effective.

Governance processes in place did not identify gaps in post leave search documentation, appropriate post incident checks not being completed and gaps in physical health checks. Although the service had daily meetings that included incident reviews, risk management and Section 17 leave they did not identify gaps in monitoring. After the inspection the service informed us, these would now be considered daily at the services morning "flash meetings".

Governance processes did not identify where staff had not logged clear links between physical health checks and risks and mental state, and the treatment plan prescribed. One of the 4 treatment plans we reviewed did not give a clear rationale around why a young person who had reached their target weight for height was being restrained to be nasogastric tube fed. There was a clear rationale around previous medical history and risk from not consuming fluids and appropriate nutrition, however, this had not been logged within care planning documentation. When we raised this with the service, they agreed there were gaps in their care planning documentation that they were looking to improve.

Audits did not identify gaps in recordings. The service had documentation to support detention under the Mental Health Act that was reviewed every 6 months and information around tribunals was in place. All young people were informed of their rights every month and the service had an MHA advocate that visited weekly. The service completed weekly multidisciplinary team ward rounds, which included attendance from the young person, and a full multidisciplinary team, which included a detailed discussion on the treatment plan, incidents and where the young person was at with their goals but did not specifically log a discussion around the review of the detention under the Mental Health Act. After the inspection the service informed us a specific section for this will now be added to the multidisciplinary team review template to ensure this is explicitly discussed and documented each week.

Requires Improvement

Specialist eating disorder services

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff had the appropriate information to provide safe care for young people. Handovers were comprehensive and included information around incidents, daily plans and specific additional support staff were required to provide.

Information management

Staff engaged actively in local and national quality improvement activities. Managers and teams used systems to manage performance effectively. Staff had regular supervisions and appraisals. The service had an internal auditing system where managers from other services conducted quality visited and produced reports and actions for improvement where required. At the time of the inspection the service were being visited by a manager from another Ellern Mede service for a quality visit.

Engagement

Managers had frequent and regular engagement with the provider collaborative in thew form of quality oversight meetings. Staff had good links with commissioners from across the country dependant on where young people were from.

Learning, continuous improvement and innovation

The provider ensured staff from the hospital attended external conferences. Staff attended discipline specific team meetings to promote learning and discuss changes in national guidance. Staff had access to bespoke training for the service including mealtime support training and eating disorders and autism.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not ensure all young people had sufficient safe and secure storage for their possessions.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure appropriate audit systems were in place to identify if post incident checks including body maps were completed after injuries were sustained and appropriate neurological and physical health checks were completed after incidents. The service did not ensure appropriate audit systems were in place to identify gaps in post leave search documentation. The service did not ensure appropriate audit systems were in place to identify if all young people's care plans included a personalised and clear narrative around the rationale for their treatment plan.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not complete searches in line with the service policy after young people had completed Section 17 leave.

This section is primarily information for the provider

Requirement notices

The service did not ensure young people's physical health checks were completed and recorded in line with the service policy and national guidelines.

The service did not ensure they completed post incident checks including neurological observations after incidents involving head banging and body maps after injuries had been sustained.

The service did not ensure staff managed items of risk on the ward which may present a potential risk to young people.