Good

South West London and St George's Mental Health NHS Trust

Specialist eating disorders services

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQY01	Springfield University Hospital, 61 Glenburnie Road, London SW17 7DJ	Avalon Ward	SW17 7DJ
RQY01	Springfield University Hospital, 61 Glenburnie Road, London SW17 7DJ	Wisteria Ward	SW17 7DJ
RQY01	Springfield University Hospital, 61 Glenburnie Road, London SW17 7DJ	Eating Disorders Day Unit	SW17 7DJ

This report describes our judgement of the quality of care provided within this core service by South West London and St George's Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated specialist eating disorder services as good overall because

- Avalon ward had made improvements since our last inspection in October 2015. When the ward was last inspected in 2015, we found that the clinic room was disorganised and unclean. During this inspection we found that the clinic rooms on the ward were clean and well organised.
- When Avalon ward was last inspected, we found that not all staff had completed their mandatory training. During the current inspection we found, that the staff training completion rate was 90%. Wisteria ward and the Eating Disorders Day Unit the training completion rates were over 80%. Staff had access to a wide range of specialist training.
- Both Avalon and Wisteria wards admitted patients from across the country and were able to care for patients with complex health needs. Avalon ward had high dependency beds.
- Avalon and Wisteria wards complied with National Health Service (NHS) guidance on same sex inpatient accommodation.
- Avalon and Wisteria wards had nursing vacancies and there was regular use of agency staff. There was a low number of unfilled shifts. Managers ensured that the wards were staffed safely. Recruitment was a priority for the trust and there was an ongoing recruitment campaign.
- The services used a range of outcome measures to determine the efficacy of the care and treatment provided. Managers had regular forums during which they could review the quality and safety of the service.
- Patients' voices were evident in their care plans.They participated in meetings and received information about their care. Patients were able to give real time feedback about their experience of care and treatment whilst on the wards.
- Parents of patients on Wisteria ward could attend a parent's group. Patients were able to personalise their bedrooms and had access to outside space
- There were doctors available to attend the wards day and night in an emergency. A full range of mental health professionals provided input into the three services. Patients were offered a range of psychological therapies. Patient treatment was evidence based and followed national guidelines.
- Staff morale in all services was high.

However, we found the following issues that the trust needs to improve:

- During the current inspection we found that on both Avalon and Wisteria wards, that the temperature of the medicine fridge was not being monitored in line with trust policy. The fridge temperature range on both wards was above the recommended range on a number of occasions. On Avalon ward this had happened on 21 ocasions between January 2017 and February 2017. On Wisteria ward this had happened on 31 occasions during the same time period. Staff could not be assured that medicines had been stored at the optimum temperature at all times.
- On Avalon ward, results of checks on the physical health of patients were not always up dated promptly in patients' electronic records.There was a risk that staff would not escalate concerns to medical staff quickly when needed.
- Staff on Avalon had not always updated patients' risk assessments after incidents. Nor had they reviewed patients' risk assessments before they went on leave. The lack of regular updates meant that staff might not be able to respond appropriately.
- Visitors to Avalon ward found that there were delays in being able to come onto the ward. Visitors pushed a door bell to let staff know they wanted to enter the ward. The door did not open automatically. Out of hours, visitors to the ward had been left outside the building and had waited for an extended period of time before they were allowed into the building.
- The ligature risk assessment for Avalon and Wisteria ward was not accurate. The assessments had not identified all the potential ligature risks on the wards.

Summary of findings

This was brought to the attention of the trust on the day of inspection. The trust updated and reviewed the ligature risk assessments for both wards immediately after the inspection.

- The blood glucose monitoring equipment on Avalon ward had not been calibrated in line with trust policy.
- On Wisteria ward, patients' dignity and privacy was not always maintained. There was a whiteboard with patient details in the nurses office that could be seen by visitors to the ward. This was brought to the attention of the trust who said they would take action to remedy this. The patients' bedroom doors had windows but there were no curtains. One patient bedroom had insufficient privacy film on the window. This meant that anybody who walked past the window could see into the bedroom.
- On Avalon and Wisteria wards the appropriate Mental Health Act documentation was in place. This information was held electronically. However, staff could not readily access this information because they were held on two separate electronic databases. There were no paper copies of the T2 or T3 forms with the medicine cards. For one patient, there was no up to date copy of the T3 form in the electronic record and for another patient the most recent T2 did not have all the medicines prescribed for the patient noted on it. We asked a member staff to find this authorisation to administer these medicines but were unable to do so. Staff who administer medicine for a mental disorder to a patient detained under the Mental Health Act must be satisfied that there is legal authority to do so.
- Staff were supposed to have 1-1 supervision sessions with their manager on a monthly basis and were supposed to have an annual appraisal. The supervision rate on Wisteria ward was low (71%). Not all staff on that ward had recieved an annual appraisal. Seventy five per cent of staff on Wisteria ward had received an annual appraisal.
- The patients and staff expressed concerns regarding the quality of the food that was being served on the wards.
- The wards did not have information available that reflected the diversity of the patient group. For example, there was no information regarding culture, sexuality, religion or gender on the wards.
- The MDT (multi-disciplinary team) on Wisteria ward had not had regular business meetings for a period of three months due to staff sickness. This meant that information was not shared easily within the team.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- On both Avalon and Wisteria ward the temperature of the medicines fridges were found to be out of range on a number of occasions. On Avalon ward this had happened on 21 ocassions and on Wisteria ward this had happened on 31 ocassions between January 2017 and February 2017. Staff had not followed trust policy by taking another temperature reading. Staff could not be assured that medicines had been stored at the optimum temperature at all times.
- Staff on Avalon ward did not always review patients' risk assessments after incidents or before they went on leave and update where necessary.
- Staff on Avalon ward monitored the physical health of patients. However, the information regarding the physical health checks was not always updated promptly in patients' electronic records. There was a risk that staff would not escalate concerns to medical staff quickly.
- The ligature risk assessments for Avalon and Wisteria wards had not identified some ligature anchor points on the ward that were in patient accessible areas.
- Visitors and patients returning from leave experienced delays in being able to come onto Avalon ward. There were reports of visitors waiting outside the ward for extended periods until staff let them in.
- Staff had not calibrated the blood glucose monitoring equipment in line with trust policy.

However, we found the following areas of good practice:

- At the inspection of Avalon ward in October 2015, we found that the clinic room was disorganised and unclean. During the current inspection, we found that all the clinic rooms were visibly clean. The clinic room on Avalon ward was well organised.
- During the 2015 inspection of Avalon ward, we found that not all staff had completed their mandatory training. During this inspection, we found that there were high completion rates of mandatory training rates for staff in all services. All three services had mandatory training completion rates over 80%.

Summary of findings

- Staff were trained in safeguarding both adults and children. There was evidence that staff made appropriate referrals if they had concerns.
- There were doctors available to attend the wards day and night in an emergency.

Are services effective?

Good

We rated effective as good because:

- Doctors considered NICE guidelines when prescribing medicines. Treatments for eating disorders were based on national guidance.
- Patients on the ward were able to access a range of evidence based psychological therapies.
- Staff had access to range of specialist training relevant to the care and treatment of patients with an eating disorder.

However we found the following issues that the trust needs to improve:

- On Avalon and Wisteria wards, the appropriate Mental Health Act documentation was in place. This information was held electronically. However,staff could not readily access this information. There were no paper copies of the T2 or T3 forms with the medicine cards. For patient, there was no up to date copy of the T3 form in the online notes and for another patient the most recent T2 did not have all the medicines prescribed to the patient noted on it.
- The MDT on Wisteria ward had not had regular business meetings for a period of three months due to staff sickness. This meant that information was not shared easily within the team.
- The supervision rate on Wisteria ward was 71% and the appraisal rate was 75% .

Are services caring?

Good

We rated caring as good because:

- Patients were given a welcome pack when they were admitted onto Avalon ward or the Eating Disorders Day unit.
- Patients had access to advocacy services.
- Patients's views were recorded in care records.
- Staff were caring and respectful. We observed positive interactions between staff and patients.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Avalon ward had three high dependency beds. This meant that staff could care for patients with complex health needs.
- There were a range of rooms available to support patient care and treatment on both wards and in the Eating Disorders Day Unit.
- Patients on both wards and the Eating Disorders Day Unit had access to a garden.
- Patients on Wisteria ward had access to education five days a week.
- Staff ensured that they started planning for patient discharge as early as possible.

However we found the following issues that the trust needs to improve

- Both staff and patients expressed concerns regarding the quality of food that was provided to patients. The trust had raised a complaint with the meals provider in February 2017.
- The privacy and dignity of patients was compromised on Wisteria ward. There was a whiteboard with patient details that was visible to visitors on the ward. The patients' bedroom doors had windows but there were no curtains. One patient bedroom had insufficient privacy film on the window. This meant that anybody who walked past the window could see into the bedroom.
- The information available to patients on both Avalon and Wisteria ward, did not reflect the diverse needs of the patient group. There was little information regarding culture, religion, sexuality or gender visible on the wards

Are services well-led?

Good

We rated well-led as good because:

- All the managers was complimentary about their teams. The staff said that they felt well supported.
- There were forums for managers to meet to discuss how to improve patient care. The operational meeting for the Eating Disorders Day Unit focused on how the unit could improve quality. Managers had access to range of dashboards, which outlined individual team performance. This meant that they could identify both good and poor performance easily.

Summary of findings

- Both Avalon and Wisteria wards had risk registers. The risk registers identified potential risks to the safety and quality of the service and the action staff needed to take to manage the risks.
- Staff felt able to raise concerns and knew about the whistleblowing policy. Staff morale in all services was high

Summary of findings

Our inspection team

The team was led by H Martin. The team comprised two CQC inspectors, one CQC assistant inspector, a specialist advisor who was a psychiatrist with experience of working in eating disorders services, a CQC pharmacist specialist and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, specialist eating disorder services.

Why we carried out this inspection

We undertook this inspection to find out whether South West London Mental Health NHS Trust had made improvements to their specialist eating disorders services since our last inspection of the trust in October 2015. We also inspected the eating disorders service for child and adolescents and the Eating Disorders Day Unit for adults.

Avalon ward is a national, specialist service providing care and treatment for male and female patients over the age of 18, experiencing severe eating disorders. At the time of the inspection, there were 22 inpatient beds on the ward. The usual length of admission is three to four months.

Wisteria ward is 12 bed ward for young people between the ages of 11 and 18 with severe eating disorders and weight loss related to mental health problems. It is a national service and accepts referrals from across the country. It accepts both male and female patients.

The Eating Disorders Day Unit is afive day service. It operates Monday to Friday during office hours and can accommodate up to ten maleand female patients over the age of 18 years. The service is for patients with a diagnosed eating disorder and whorequire a more intensive treatment programme of care and treatment than could be offered by the community mental health teams. The Eating Disorders Day unit only accepts referrals from the five local boroughs. The average length of stay is nine months. It accepts referrals from the adult inpatient specialist eating disorders service and the trust's community mental health teams

We last undertook a focused inspection of the adult inpatient specialist eating disorders services (Avalon ward) in October 2015. Following the inspection we told the trust it must make the following actions to improve specialist eating disorders services:

- The provider must ensure that staff complete mandatory training in adult basic life support, medicines management and fire safety awareness.

This related to the following regulations under the Health and Social Care Act (Regulated Activities)

Regulations 2014: Regulation 18 Staffing.

We last inspected the children and adolescent mental health inpatient specialist eating disorders services and Eating Disorders Day Unit in March 2014. At that time the services were meeting essential standards, now known as fundamental standards.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service.

This was an unannounced inspection. During the inspection visit, the inspection team:

- visited Avalon ward, Wisteria ward and the Eating Disorders Day Unit, looked at the quality of the environment and observed how staff were caring for patients

Summary of findings

- spoke with 14 patients who had been admitted into these services
- spoke with a carer
- spoke with the ward manager for Avalon and Wisteria wards and the service manager for the Eating Disorders Day Unit
- spoke 11 other staff members; including doctors, nurses, psychologists, administrators and outreach staff
- attended and observed a community meeting on Avalon ward
- looked at 12 care and treatment records of patientscarried out a specific check of the medication management on the two wards and the Eating Disorders Day Unit
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with fourteen patients. We received a mixture of both positive and negative comments. The majority of patients told us that they received good care and treatment from staff. On Avalon ward and in the Eating Disorders Day Unit, the patients were complimentary about the multi-disciplinary team.

Patients on Avalon ward felt that the the daily community meetings were useful. It gave themthe opportunity to discuss concerns. However, they felt that changes that were happening on the ward sometimes took place without consultation. All the patients we spoke with on Avalon ward were concerned about changes to the morning snack. Patients on both Avalon and Wisteria ward were concerned about the quality of the food that was provided. Patients stated that food was fatty and full of gristle. There had also been an incident on Wisteria where patients had found pieces of bone and hair in the food.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that medicines are stored at the correct temperature and that trust policy is followed when the fridge temperatures are found to be outside the accepted range.
- The trust must ensure that information about patients' physical health care is recorded accurately and that the information is transferred promptly on to patients' electronic records so that it can be followed up quickly when concerns are identified.
- The trust must ensure that patients' risk assessments are updated in a timely manner and in line with trust policy.

Action the provider SHOULD take to improve

- The trust should ensure that the MDT on Wisteria ward have regular business meetings so that information is shared within the team.
- The trust should ensure that there are processes in place to allow visitors and patients to be able access Avalon ward without unnecessary delays.
- The trust should ensure that ligature risk assessments are up to date, identify potential ligatures and state how they will be managed.
- The trust should ensure that patient information is not visible to other patients and visitors and viewing panels into patients' bedrooms can be covered so that patients' privacy, dignity and confidentiality is maintained
- The trust should ensure that blood glucose monitoring equipment is calibrated in line with trust policy.
- The trust should ensure that staff can easily access T2 and T3 forms and that staff can check that they have the legal authority to administer medicines before they are administered.
- The trust should ensure that staff on Wisteria ward have regular supervision and annual appraisals.
- The trust should ensure that they continue to monitor the quality of food provided to patients.

Summary of findings

- The trust should ensure that they provide information that reflects the diversity of the patient group.

South West London and St George's Mental Health NHS Trust

Specialist eating disorders services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Avalon ward	Springfield University Hospital, 61 Glenburnie Road London SW17 7DJ
Wisteria ward	Springfield University Hospital, 61 Glenburnie Road London SW17 7DJ
Eating Disorder Day Unit	Springfield University Hospital, 61 Glenburnie Road London SW17 7DJ

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The trust provided staff with training in the Mental Health Act (MHA).The MHA training completion rate was 80% on Avalon ward and 85% on Wisteria Ward.
- The mental health documentation we reviewed was completed and stored appropriately. Patients' consent to treatment was recorded on their health care records.
- Independent mental health advocacy services were available for patients who were detained under the Mental Health Act.
- Although the appropriate legal authorities for the medicines to be administered were in place they were not kept with patient medicine administration records. This meant staff could not see the T2 or T3 forms at the time they administered medicines. The Mental Health Act Code of Practice states that it is good practice for a

copy of the certificate relating to medication to be kept with the patient's medicine chart to minimise the risk of the patient being given treatment in contravention of the Act.

- The pharmacist on Wisteria ward, undertook audits of medicines and the associated Mental Health Act paperwork. Where errors were identified they ensured that they notified the relevant members of staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Wisteria ward admitted young people aged 11 – 18 years. The Mental Capacity Act (MCA) does not apply to young people aged 16 and under. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves.
- The trust had provided staff on Wisteria ward with 'Deprivation of Liberty and Under 18 year olds' and 'understanding and working with different legal frameworks' training in December 2016. The training completion rate for Wisteria ward staff was 85%. The Mental Capacity Act training completion rate was 80% for staff on Avalon ward.
- Staff considered the capacity and competence of each patient.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Avalon, Wisteria and the Eating Disorder Day unit had systems to monitor visitors to the ward/service. The Eating Disorder Day Unit was located in a building with a main reception area, which was staffed during office hours. Wisteria ward was in a purpose built building. Access to the ward was via an airlock system. Avalon ward was located on the second floor of a building that accommodated a number of other mental health teams. During the day, visitors were able to access the second floor without signing in at the ground floor reception area. Visitors and patients coming onto Avalon ward who wanted to access the ward had to ring the doorbell, which was located directly outside the ward. Staff had to come to the door to let visitors in. Out of hours, visitors and patients returning to Avalon ward had to ring the "night bell", which was by the entrance to the ground floor. Some visitors to Avalon ward complained that it was difficult to access the ward out of hours and they had been left waiting outside the building for over 10 minutes in the dark.
- Both Avalon and Wisteria wards complied with NHS guidance on same sex inpatient accommodation. On Avalon ward, male and female patients were on the same floor but they had separate areas of the ward, which included separate lounges. Wisteria ward was laid out over two floors. On both wards, male patients did not have to pass female areas to use the bathrooms or vice versa.
- Wisteria ward had several blind spots, meaning staff could not see all patients at all times. Staff mitigated this risk with regular observations of patients and increased observations where a high level of risk was identified.
- Staff managed ligature risks on the ward through keeping high risk areas locked unless a patient was accompanied by staff, through individual risk assessments and regular observations. All three services had specific ligature risk assessments. A ligature anchor point is an environmental feature or structure, to which patients may fix a ligature with the intention of harming themselves. Staff on Avalon and Wisteria wards had completed ligature risk assessments of the wards. Both ligature risk assessments had not identified all the ligature anchor points on the wards. On Avalon ward the ligature risk assessment had not identified a ligature anchor point in the male only lounge. This lounge was unlocked on the day of the inspection and patients could access the room at will. The lounge contained a wall mounted television. The television wall bracket and the television cables could have been used as a ligature. On Wisteria ward the ligature risk assessment did not reflect the current ward environment fully. During the inspection we saw staff had not identified two communal areas of the ward on the ligature assessment and one area contained clear ligatures which were two electrical boxes which could easily be reached by patients. The ligature risks we identified during our inspection on both wards were highlighted to the respective ward managers on the day of the inspection. After the inspection, the trust reviewed and updated the ligature risk assessments for both wards. The trust also requested that the staff on the ward control access to high risk areas until the ligatures were removed. Staff in the day unit were aware of the ligature risks in the environement. The patients attending the day unit were assessed as low risk. They returned to their homes in the evening.
- Both Avalon and Wisteria wards had alarm systems which allowed patients and staff to summon assistance if required. The Eating Disorders Day Unit did not have alarms, because it was felt that the alarms would disrupt the therapeutic atmosphere.
- None of the wards had a seclusion room.
- All three services were visibly clean. An external company was contracted to carry out the cleaning of the wards. The domestic staff were visible on the ward. Staff monitored the cleanliness of the wards on a regular basis. For example in the Eating Disorders Day Unit, a weekly audit was undertaken by the lead domestic.
- Both Avalon and Wisteria wards had participated in the patient led assessment of care environment (PLACE) within the last 12 months. Avalon ward had been

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

assessed in May 2016. The ward had scored 99% for cleanliness, 83% for privacy and 95% for appearance and maintenance. Wisteria ward had been assessed in April 2016 the ward had scored 97% for cleanliness, 83% for privacy and 94% for appearance and maintenance.

- When Avalon ward was last inspected in October 2015, we found that the clinic rooms were disorganised and unclean. During the current inspection, we found that both clinic rooms were clean and well organised. The fridge was clean and only contained medicines, all of which were in date. The ward manager on Avalon ward undertook quarterly audits of the clinic room, they audited the cleanliness of the environment and checked the contents of the medicines fridge. The clinic room on Wisteria ward, although clean was small. It was difficult to access the fridge due to the physical health monitoring equipment that was stored directly in front of it. The clinic room on the Eating Disorder Day Unit was clean and tidy.
- The staff on Avalon, Wisteria wards and the Eating Disorder Day unit stored medicinces and emergency life support equipment appropriately in the clinic rooms. Records showed staff carried out daily checks on the emergency equipment to ensure it was ready for use. On Avalon ward, we found that the blood glucose monitoring machine was not being calibrated on a weekly basis. The machine was calibrated twice in October 2016, twice in November 2016, three times in December 2016 and once during February 2017. January 2017 was the only month that the blood glucose monitoring machine had been checked weekly.

Safe staffing

- The nurses on both Avalon and Wisteria wards worked 12 hour shifts. The staff who worked in the Eating Disorders Day unit worked office hours. On Wisteria ward, the trust had recently increased the required staffing levels following consultation with staff. The requirement was now five staff during the day and four staff at night. This included at least two qualified nurses at all times.
- The Eating Disorders Day Unit was fully staffed. However, there were vacancies for both qualified and unqualified staff on both wards. On Avalon ward, there were vacancies for a band 5 nurse, 3.4 whole time equivalent (wte) band 4 vacancies and 2.6 wte band 3 vacancies. Three full-time and one part-time band 4 and 2 full-time and 1 part-time band 3 support workers. On Wisteria ward, there were vacancies for one band 5 nurse, three full-time band 4 and three full-time band 3 support workers. The trust had an active programme of ongoing recruitment.
- Both wards used bank and agency staff to cover shifts. Between December 2016 and February 2017, 240 shifts had been covered by bank or agency staff on Avalon ward. On Wisteria ward, 530 shifts had been covered by bank or agency staff. During this period, Wisteria ward had a number of patients who required nasogastric feeding. The trust stated that this had led to a greater use of agency and bank staff to support the additional need for physical interventions. Whenever possible the wards tried to use bank and agency staff that were familiar with the ward and working with patients who had an eating disorder.
- Although the wards endeavoured to fill shifts with agency or bank staff, this was not always possible. Between December 2016 and February 2017, 16 shifts were unfilled on Avalon ward. During the same time period, 14 shifts were unfilled on Wisteria ward. On these occasions, the trust sometimes deployed staff from other wards, either for the whole shift or a number of hours, in particular to assist with tasks that required additional staff. For each shift not filled the safer staffing position was reviewed by the matron and ward manager to ensure that ward safety was maintained.
- The average rate of staff sickness between February 2016 and January 2017 on Avalon ward was 5%, on Wisteria ward it was 4% and on the Eating Disorders Day unit it was 2%.
- All three services had a number of staff that had left between March 2016 to February 2017. The turnover rates were 44% on Wisteria ward, 18% on Avalon ward and 13% in the Eating Disorders Day Unit. The high turnover of staff on Wisteria ward was attributed to a number of newly recruited staff leaving shortly after being appointed because they wanted to work with a different patient group. The trust had implemented a number of initiatives to improve retention rates. These initiatives included a bespoke and comprehensive induction programme, learning events and six month work placements for established band 5 nurses.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- There were doctors available to attend the wards day and night in an emergency.
- Staff had a programme of statutory and mandatory training. When Avalon ward was last inspected in October 2015, we found that not all staff had completed their training requirements. There were low completion rates of adult basic life support, medicines management and fire safety awareness. During the current inspection, we found that there had been an improvement in this area. The staff training completion rate for the ward was now 90%. The training completion rate for Wisteria ward was 83% and was 98% for the Eating Disorders Day Unit (these figures included staff who were booked to attend training).

Assessing and managing risk to patients and staff

- There had not been any incidents of seclusion or long term segregation in the last six months on either Avalon or Wisteria wards.
- Between September 2016 and February 2017 there were ten incidents of restraint on Avalon ward and 20 incidents of restraint on Wisteria ward. None of these restraints were in the prone position. On Avalon ward there were five incidents of restraint for nasogastric (NG) feeding (these incidents related to two patients). There were seven incidents of restraint for NG feeding on Wisteria ward (these incidents related to two patients). The higher incidence of restraint for NG feeding on Wisteria ward was because of the higher physical risk posed to children with an eating disorder.
- Most staff told us they had received training in de-escalation techniques and proactive preventive interventions, which included how to safely restrain a patient with low body mass index. On Avalon ward, staff provided patients with 1-1 support after restraint in order to offer explanation and rationale and to facilitate de escalation.
- When Avalon ward was last inspected in October 2015, we found that patient risk assessments and management plans were not always reviewed and updated following risk incidents. After the last inspection, we told the trust that they should ensure that risk assessements were updated after risk incidents. During the current inspection we reviewed four risk assessments. We found that staff were not routinely updating risk assessments. For example, for one patient there had been a change in their clinical presentation on the 13/02/17, which had led them being place on increased observations. The risk assessment had not been updated, nor had the risk management plan. For another patient there had been an incident, but the risk assessment had not been update and there were no management plans in place to mitigate the increased risk. We also found that staff were not routinely undertaking a risk assessment for patients prior to going on leave. This meant that staff would not be aware of how best to mitigate the risk posed to patients. For example, in one of the records we reviewed, staff noted in January 2017 in the risk assessment that a patient's behaviour presented a risk to themselves. The patient had been overnight leave on two occasions since the risk had been identified.However, there were no risk management plans to mitigate increased the risk.
- We reviewed seven risk assessments for Wisteria ward and the Eating Disorders Day Unit. Staff assessed risks for patients admitted in a timely way. There were risk assessments in the case records we looked at. The risk assessments covered several areas of risk and were linked to management plans. We saw that staff updated risk assessment documents when an incident occurred. Where incidents had not occurred, we saw that staff marked risk assessments as reviewed and updated every one to four months. Staff used the trust risk assessment tool on the electronic record system.
- Staff checked patients' vital signs to ensure there was prompt identification of potential physical health problems. The results of the checks were recorded on early warning scores charts. Both Avalon ward and the Eating Disorders Day Unit used adult specific modified early warning system (MEWS). Staff on Wisteria ward undertook these checks on a regular basis. The staff used charts designed for paediatrics, the paediatric early warning system (PEWS). On the Eating Disorders Day Unit physical health monitoring of patients was carried out routinely once a week.
- When Avalon ward was last inspected in October 2015, we found that patients' MEWS charts had gaps and that the electronic monitoring system had not been updated immediately with information from the MEWS charts. After that inspection, we told the trust that they should make improvements. During the current inspection, we found that staff had undertaken an audit of MEWS

completion on Avalon ward in January 2017. The audit identified that the information from the MEWS charts was not being uploaded onto the electronic monitoring system in a timely fashion. The ward manager had implemented a system, whereby night staff checked the paper-based MEWS charts during the night shifts. Night staff were expected to ensure that information from the MEWS charts was uploaded onto the electronic system. Although this system was in place, it still required further embedding. The ward manager had identified that there was still inconsistent practice with regard to the completion and uploading of MEWS charts. The issue had been raised in staff business meetings twice in February 2017 and once in March 2017. During the current inspection, we found that MEWS scores were sometimes recorded in progress notes, even though there was a specific area on the electronic monitoring system where it should have been recorded. We reviewed eight MEWS charts and found that six charts had gaps in the recordings and it was unclear whether the patient had received appropriate physical health monitoring. For one patient, the scores on the MEWS charts differed from the scores that were recorded on the electronic monitoring system. For five patients there were no total scores recorded. This meant staff could not be assured that the patients had not attained a trigger score, which would indicate that their physical health was deteriorating. Patients who have an eating disorder are at high risk of physical health issues. We pointed out the gaps in MEWS charts on the first day of the inspection to the ward manager. We noted that on second day the ward manager had put a reminder for staff to complete the MEWS charts in full in the folder where the MEWS charts were stored.

- Blanket restrictions were used only when justified. The trust had a clear policy in place to protect privacy and dignity. Patients were not allowed to use smartphones to take pictures or record individuals on the ward. There were posters displayed on the wards making this clear. If patients on Avalon and Wisteria ward could not adhere the policy the ward staff could give patients mobile phones, which did not have cameras. This ensured patient confidentiality was maintained whilst on the ward.
- Informal patients on both Avalon and Wisteria wards could leave at will. There was written information on the front door of Wisteria ward for informal patients about their right to leave the ward and the risk assessments that staff should carry out before informal patients left the ward. For example, if there were very significant concerns about medical risk due to very low weight staff might intervene if an informal patient wished to leave the ward.
- IStaff undertook regular observations on Wisteria ward and this was clearly documented in patient notes. On Avalon ward, staff undertook room searches. Patients were made aware that room searches would take place. Room searches were based on individual risk. Contraband items included laxatives and certain soft drinks.
- Staff were trained in safeguarding and could describe how to identify and report abuse. The training completion rates for safeguarding adults on Avalon ward were 97% (one member of staff had not completed this training), on Wisteria ward and on the Eating Disorders Day Unit the completion rate for this training was 100%. The training completion rate for safeguarding children and young people for staff on Avalon ward and the Eating Disorders Day Unit was 100% and the completion rate on Wisteria ward was 96%.
- On Wisteria ward, records showed that staff identified, discussed and acted upon safeguarding concerns appropriately. For one young person there was not a detailed description of an action plan to address identified concerns but staff were aware of how to mitigate risks. On Avalon ward, we saw an example of staff responding in a timely way when a patient disclosed possible safeguarding concerns. The action taken by staff was clearly documented and there was evidence of staff supporting the patient appropriately and ensuring that the patient's wishes were taken into consideration.
- The wards had designated visiting times. On Avalon ward, vulnerable visitors, for example children, were restricted to the visiting area to ensure their safety.The Eating Disorders Day Unit did not have designated visiting times as this was a day service.
- On both Avalon and Wisteria wards, medicines were stored securely in a locked treatment room and only authorised staff had access to the treatment room.
- The staff in the Eating Disorders Day Unit managed medicines appropriately. Emergency medicines were

checked daily. The staff on the unit documented these checks. The expiry dates of medicines held in emergency bags was written on white board in clinic room.

- On both wards, the fridge temperature had been outside the accepted temperature range on a number of occasions. On Avalon ward, this occured on 21 occasions during January and February 2017. On Wisteria ward, the fridge temperature was outside the accepted range on 31 occasions. Medicines should be stored under conditions which ensure that their quality is maintained. The trust could not be assured that the medicines would still be effective due to the fluctuations in temperature. Staff had not taken appropriate action as per trust policy. The policy stated that a second reading should be taken after two hours if the fridge temperature was outside the recommended range. The fridge on the Eating Disorders Day Unit, did not have any medicines stored in it.
- On both Avalon and Wisteria wards, staff recorded if patients were allergic to any medicine. This information was recorded on their electronic prescription chart. Medicine reconciliation was completed on all prescription charts in a timely manner.
- We saw appropriate arrangements were in place for recording electronically the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them.
- Pharmacist interventions were recorded on the electronic prescription chart, so that both prescribers and nurses administering the medication were aware.

Track record on safety

- Between March 2016 to February 2017, there were three serious incidents on Avalon ward and five serious incidents on Wisteria ward. There were no reported serious incidents in the Eating Disorders Day Unit. The incidents on Avalon ward were dissimilar and there was evidence that the ward had reviewed the circumstances of incidents and learned from them. They had made improvements.For example, as a result of staff misplacing keys the ward had introduced a checklist to ensure keys were logged in and out. On Wisteria ward three of the incidents were related to incidents of patient self-harm, one related to a medication error and the other was a personal accident. In all cases the incident was shared for learning with all staff.

Reporting incidents and learning from when things go wrong

- Staff used an online reporting system to report incidents. We reviewed an incident form completed by staff on Avalon ward. We found that the form had been completed within 24 hours of the incident occurring. The severity of the incident had been discussed and an action plan had been implemented. The trust sent out monthly reviews of bulletins, which disseminated learning from incidents that had happened in the trust to all staff.
- The number of incidents recorded from March 2016 to February 2017, was 204 on Avalon ward, 417 on Wisteria ward and 29 incidents on the Day Unit. There were a broad range of incidents reported, which included incidents related to the environment, patients and staff. The wards reported restraint for NG feeding as incidents.
- The ward manager and staff on Wisteria ward said incidents were discussed at handovers. We checked business meeting minutes on Avalon ward and saw that incidents were discussed. There were some examples of changes being made as result of incidents. However, this did not happen on every occasion. For example, there was an incident on Avalon ward where a knife went missing. The ward manager had reviewed the circumstances and believed the knife had been thrown in the bin. The ward manager urged staff to be careful and ensure that sharp items were returned and this was recorded in the minutes of the meeting. However, there were no measures put in place to ensure that they could check that all knives had been returned. There was also an incident on the same ward where a patient was not provided with their prescribed medication to take with out with them when they went on home leave. After this incident, the staff had discussed the incident. They had identified the lessons learned, which included changing the system for ordering medication for patients going home on leave.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed 12 patient care records across the three services. We found that staff assessed patients' physical health needs on admission and supported them with accessing appropriate intervention. On Wisteria ward we reviewed five records. For one patient on this ward, there was no evidence that staff had referred them for regular electrocardiograms (ECG). This is a test to check the heart's rhythm and electrical activity and was required due to the dose of medicine being prescribed. Staff said these had taken place, but there was no record of these in the patient notes. Patients who attended the Eating Disorders Day Unit also had a comprehensive health assessment, which included a referral for a bone scan if appropriate Staff provided patients with ongoing physical health monitoring.For example, the Eating Disorders Day Unit held a weekly physical health clinic. If patients had additional physical health needs unconnected to their eating disorders they were supported to access medical support from their own GP.
- In the five care records we looked at on Wisteria ward, patients had a range of care plans for different needs. These were generally personalised and recovery orientated. Staff updated care plans every one to four months. Each patient had a care plan called personal recovery goals. These included a range of goals written by the patient and were personalised and recovery orientated. Patient views were recorded in most care plans. This demonstrated staff created or discussed the care plans with patients. The recording of patient views varied in detail. It ranged from a sentence stating the patient agreed, to longer and more detailed descriptions written in the first person.
- In the three care plans we reviewed for patients on the Eating Disorders Day Unit, the care plans were detailed and holistic. The goals on these care plans were recovery orientated and regularly updated. Where patients had met specific goals in their care plans, these had been reviewed and the goal was noted on the care plan as having been met.
- We reviewed four care plans for patients on Avalon ward. All patients had an up to date care plan. Two patients had received regular reviews of their care plans. The plans were holistic and the views of the patients were recorded. However, for one patient there had been a change in their clinical presentation, which had led to changes in the care and treatment that would be provided for the patient. This was not noted in the care plan. For another patient, the care plans had not been reviewed on a regular basis.
- Patients who attended the Eating Disorder Day Unit had crisis care plans, which identified what support the patient could access if they started to become on unwell out of hours. Staff and patients formulated these crisis plans together. The staff used a questionnaire that asked three questions about patients' thoughts and feelings. Staff read through the patient's responses and this helped staff and patients put action plans in place in times of crisis.
- Staff recorded in patient notes when "as required" medication was given. The notes included information about when this was given, what it was given for and what the dose was. This also allowed medical staff to monitor how frequently it was given.
- Information about patient care was stored securely on an electronic record system. Permanent staff could access this when needed. However, agency and bank staff could not. This meant that permanent staff were responsible for inputting information onto the electronic records system on behalf of bank and agency staff.

Best practice in treatment and care

- The doctors considered National Institute for Health and Care Excellence (NICE) guidelines when prescribing medicines. Treatments for eating disorders were based on national guidance which included the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) and Junior MARSIPAN.
- Patients on the ward were able to access a range of psychological therapies recommended by evidence based guidance. This included cognitive behavioural therapy and family therapy. On the Eating Disorders Day Unit, patients attended a food group, which was led by a dietician. Patients were also offered psychodrama sessions (led by psychodrama therapist). Patients were able to access ten addtional sessions of psychodrama sessions once they were discharged from the service.

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- Staff on Wisteria ward used recognised ratings scales to assess and record severity and outcomes. This included the Children's Global Assessment Scale and the Health of the Nation Outcome Scale for children. Staff completed these within two days of admission to the service and when the young person was discharged. Staff on Avalon ward completed Health of the Nation Outcome Scales (HoNOS). HoNOS covered 12 health and social domains and enabled the clinicians to build up a picture over time of patients' responses to interventions. Staff completed this at the beginning and end of patients' treatment to measure progress.
- Some staff were involved in clinical audit and carried out audits of care plans on both Avalon and Wisteria wards. This was done on a monthly basis on Wisteria ward The audit had ten questions including whether patient views were included, were up to date care needs reflected, and were copies of care plans provided. The most recent care plan audit undertaken on Avalon ward in January 2017 focused on whether the care plan was present and not the quality of the care plan.

Skilled staff to deliver care

- A full range of mental health professionals provided input to the three services. This included psychiatrists, nurses, healthcare assistants, psychologists, occupational therapists, music and art therapist, social workers and family therapists. The dietitian who worked on Wisteria ward provided consultative support to Avalon ward as the dietitian attached to that ward was on maternity leave. There was also a vacancy for a part-time phlebotomist on Avalon ward. A locum was covering the post.
- The trust provided a two week induction process for permanent staff. There was no formal training offered by the trust about eating disorders. New staff on Avalon and Wisteria ward were provided with a ward specific induction as well as the trust induction. The induction on Avalon ward included training about meal times, for example how to measure and prepare meals for patients and appropriate strategies to support patients during meal times.
- MDT staff did not have regular business meetings on Wisteria ward due to staff sickness. Staff told us that meetings did not take place and no meetings were minuted. This meant that there was no forum to discuss incidents, complaints and audit outcomes and so there was a risk that key learning was not being shared across the ward.
- Staff working on the Eating Disorders Day Unit had a monthly team meeting and a weekly business meeting.
- At the time of inspection, 11 staff out of 14 (79%) on Avalon ward and ten staff out of 12 (83%) on Wisteria ward had been trained in naso-gastric feeding (NG). The trust had not run this whole day training for the six months prior to inspection, due to having insufficient numbers of staff being available to attend. The trust had scheduled another training course in NG feeding for April 2017. All staff that had not received this training were scheduled to attend this course. The NG feeding training provided to staff also included information on the medical complications of anorexia nervosa, proactive physical intervention techniques in assisted feeding, tube insertion techniques and refeeding syndrome. Refeeding syndrome can occur at the beginning of treatment for anorexia nervosa when patients have an increase in calorie intake and can be fatal.
- Staff also received other specialist training. This included weekly learning events on Avalon ward presented by a range of internal and external speakers, dialectical behaviour therapy training for staff on Wisteria ward and national knowledge understanding framework personality disorder training for staff who worked on the Eating Disorder Day Unit. All staff had access to reflective practice sessions and were able to attend specialist eating disorder conferences.
- The completed staff appraisal rate for the Day Unit was 100% and the supervision rate was 100 %. The supervision rate for Avalon ward was identified as an area for improvement in December 2016, when it was 64%. Since then the rate had improved and at the point inspection it was 95%. The completed staff appraisal rate on Avalon ward was 98%. The supervision rate on Wisteria ward was 71% and the appraisal rate was 75%. Supervision ensures that staff work within professional codes of conduct and boundaries and training needs are identified. Supervision can help ensure that patients receive high quality care at all times from staff.

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Supervision supports staff to manage the personal and emotional impact of their practice. An appraisal allows managers to review their overall performance and identify areas for improvement.

Multi-disciplinary and inter-agency team work

- Ward rounds were held each week on Wisteria ward. At ward rounds staff from each discipline discussed the needs of each patient and considered plans for ongoing care. We saw in records that patients, families and external professionals were invited to and contributed to these meetings. Records from ward rounds were saved into the electronic record system and showed detailed and personalised discussions about patient care.
- Staff who worked on the Eating Disorders Day Unit regularly liaised with local community mental health teams. The staff team were also developing better working links with Avalon ward to ensure that patients who were being discharged from the inpatient ward to the day Unit were better supported.
- Staff on Wisteria ward attended handover meetings between each shift to share details of any important information or incidents that occurred.
- Staff from all disciplines recorded detailed entries in the progress notes on the electronic system.

Adherence to the MHA and the MHA Code of Practice

- Avalon ward had nine detained patients and 13 informal patients at the time of the inspection. Detention documentation we reviewed for this ward was in order and stored appropriately.
- The trust had provided staff with training on the Mental Health Act (MHA) on 23 November 2016. This training had been attended by nurses, ward manager and multidisciplinary staff. There had also been refresher sessions conducted as part of the team learning monthly sessions/events.
- The MHA training completion rate for staff was 80% on Avalon ward and 85% on Wisteria Ward.
- When people were detained under the Mental Health Act, the appropriate legal authorities for the medicines to be administered were in place. However on Wisteria ward, they were not readily accessible to staff administering the medicine, this meant that nurses were not always able to check that medicines had been authorised before administration. For one patient we found that the T3 form was not present in the patient electronic record, so could not be checked prior to administration. The new T3 was completed on the 06/01/2017 but this had not been uploaded onto the electronic system. Another patient, had two medicines administered on 19/02/2017, which should have been noted on a T2. A T2 form had been completed 22/02/2017 but did include the two medicines that had been prescribed to the patient, these continued to be available until seen by pharmacist on 27/02/2017. The Mental Health Code of Practice (s25.75) states that it is good practice for original signed certificates to be kept with the documents which authorise the patient's detention or CTO, and copies should be kept in the patient's notes. As a matter of good practice, a copy of the certificate relating to medication should be kept with the patient's medicine chart (if there is one) to minimise the risk of the patient being given treatment in contravention of the provisions of the Act.
- The pharmacist on Wisteria ward, undertook audits of medicines and the associated MHA paperwork. Where errors were identified the pharmacist ensured that the notified the relevant members of staff.

Good practice in applying the MCA

- The Mental Capacity Act (MCA) applies to young people aged 16 and over. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves.
- The trust had provided staff on Wisteria ward with 'Deprivation of Liberty and Under 18 year olds' and 'Understanding and working with different legal frameworks' training in December 2016. The training was facilitated by an external trainer. Eighty five per cent of staff on Wisteria ward had completed the training.
- The MCA training completion rate for staff was 80% on Avalon ward.
- During the inspection we found that records showed staff considered the capacity and competence of each patient at each ward round.

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- On Avalon ward, the social worker led on MCA. They also audited MCA assessments and entries on the electronic patient records.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff spoke respectfully about patients and we saw positive interactions between staff and patients. Staff had were aware of individual patient preferences.
- Patients on Avalon ward were complimentary about the pscychology team and the work undertaken by the occupational therapy teams. Four patients on both Avalon and Wisteria ward felt that some staff were not sufficiently experienced in working with patients with eating disorders. This lack of experience meant that staff sometimes did not respond in a way that was supportive. We spoke to four patients on Wisteria ward. Two patients commented that when they had raised concerns regarding aspects of their care and treatmentthwy felt that their concerns had been minimised. All the patients we spoke to in the Eating Disorders Day Unit, were positive about the care and treatment they had received. These patients felt that the staff had a good understanding of their individual needs and were supportive.

The involvement of people in the care they receive

- On Avalon ward, newly admitted patients received a welcome pack. The patient welcome pack contained information on the advocacy service, confidentiality, consent to treatment and information regarding ward rules. Patients on both wards had access to advocacy services. Patients who used the Eating Disorders Day Unit, were given an information booklet, which outlined the unit's ethos and philosophy, the groupwork programme and what a patient could expect on their first day.
- Patients could give real time feedback anonymously on a tablet computer. Patients could comment on the care they received and other issues for example, the ward environment. The young people on Wisteria ward said that they were reluctant to use the tablet computer due to having to complete an online questionnaire before submitting their comments. They found the process onerous and off putting. We reviewed the real time feedback responses between December 2016 and February 2017. There were six comments submitted by patients on Avalon ward during that period. There was one compliment and one non specific comment and the other four identified areas for improvement on the ward. Two pieces of feedback identified that newly admitted patients required more support. The other piece of feedback identified that the care planning process on the ward needed to be improved. There were seven responses from Wisteria ward patients. Three responses were positive and included comments that indicated that the staff were helpful and supportive. One comment was non-specific. The other three comments were negative. The trust had indicated what they intended to do as a result of the feedback from the patients. Actions included sharing the comments with the staff on the wards. There were no comments submitted by the patients on the Eating Disorders Day Unit.
- On Avalon ward, there was a patient board in the ward corridor. This displayed information for patients. For example, there was information for informal patients that explained their rights and what patients could expect with regards to their treatment.
- Ward based community meetings were held daily on Avalon and Wisteria wards. These meetings were attended by staff and patients and gave the opportunity for patients to express their views. As part of our inspection of the ward we attended a community meeting on Avalon ward. The meeting was chaired by a patient and minuted. Eleven patients and three staff were in attendance. All patients could contribute to the meeting even if they did not wish to attend in person. There were facilities for patients to submit comments via a feedback box. The comment cards were reviewed and discussed during the community meeting. Community meetings were held twice weekly on the Eating Disorders Day Unit. The meeting was chaired by patients on a rota basis and followed a standard agenda. Agenda items included lifestyles ideas, community dynamics and new admissions. These meetings were minuted and available to the patients after the meeting.
- Care records on Wisteria and the Eating Disorders Day Unit, showed that staff discussed care with patients. Patient views were recorded in the records and taken into account. For example, where a patient requested daily phone contact from staff whilst on home leave, staff recorded when they called, whether they were able to get through and summarised what was discussed.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Staff recorded conversations and input from carers and families in patient notes. Staff on Wisteria ward recorded when patients did or did not consent to information being shared with their parents.

- Parents and carers for young people on Wisteria ward were able to attend a weekly parent support group run at the service.
- Patients on Avalon ward were unable to have one to one meetings with a dietitian because the ward did not have designated dietitian. The dietician on Wisteria ward was only able to provide advice to staff. The staff on Avalon ward felt that this did not impact on patients and that the multi-disciplinary team on the ward were able to support patients with individualised meal plans. One patient felt that not having a dietitian attached to the ward was a problem as they were no longer able to have one to one sessions with the dietitian.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Avalon and Wisteria wards provided national eating disorders services and admitted patients from across the country. Avalon ward was for adults aged 18 years and over. Wisteria ward was for young people aged 11-18 years. The Eating Disorders Day Unit admitted patients aged over 18 from Richmond, Kingston, Sutton, Merton and Wandsworth.The ED community service received most of its referrals from the Eating Disorders community service which come via GPs and some local patients from Avalon. Whenever, possible services ensured that admissions were planned in advance. The wards had regular bed-planning meetings. The Eating Disorders Day Unit was able to take emergency admissions in an effort to stabilise individuals who were at risk of being admitted into hospital. The unit monitored newly admitted patients for two to six weeks to assess willingness to commit to the programme.
- In November 2016, Avalon ward had increased the number of inpatient beds on the ward from 18 to 24. The average bed occupancy on Avalon ward between September 2016 and February 2017 was 83%. Wisteria ward could admit up to 12 patients. The average bed occupancy on this ward during the same period was 100%. The Eating Disorders Day Unit was commissioned to admit up to seven patients but could admit up to nine patients.
- Both wards did not use leave beds for admissions. There were no reports from either ward that patients did not have access to a bed when they returned from leave between September 2016 and February 2017.
- Discharge planning for patients started early. The ward manager on Avalon ward stated that a lack of provision in local areas sometimes delayed discharge. Some patients on this ward had been on the ward for over two years due to their individual needs and because there were no beds available in their home area. We saw staff on these ward liaising with patients' care co-ordinators to ensure appropriate arrangements were in place for those who were ready to be discharged. There was one delayed discharge on Avalon ward at the time of inspection. There were no delayed discharges on Wisteria ward, in the six months before the inspection.
- On the Eating Disorders Day Unit, patients attended the programme for approximately nine months. The patients on the unit tended to be discharged back to the outpatient service. However, if they became unwell they could be admitted to Avalon ward. Planning for routine discharge started approximately six months before the patient was due to be discharged. Staff on the Eating Disorders Day Unit stated that there were sometimes delays in discharging patients if they came in for assessment and it was identified that they had other mental health needs that could not be met by the community mental health teams. In preparation for discharge from the unit, patients reduced the number of days they attended the programme.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a range of rooms available on Avalon and Wisteria ward to support patient care. On Avalon ward there were separate quiet rooms for the male and female patients. On both wards and on the Eating Disorders Day Unit there was a lounge that accommodated all patients.
- On the second floor of Wisteria ward there were a range of staff offices, a staff room with kitchen and several therapy rooms. There was a dedicated psychotherapy and psychological therapy room, an activities room and a family therapy room with a viewing panel. The ward had three dining rooms and an extra space for patients to be supported with naso gastric feeding. The dining rooms were separated into levels and patients requiring different levels of support could eat in each room. One of these was used mainly for family meals, which were not supervised by staff.
- The Eating Disorders Day Unit did not have designated therapy rooms and shared premises with outpatient services. The therapy rooms were not always available. This meant that patients sometimes had to have their therapy sessions in the dining room. Staff felt this was not always therapeutic for patients. The Eating Disorders Day Unit had a dining room and kitchen, which was well equipped and well-maintained.
- The patients on the Eating Disorders Day Unit had their own designated comfortable chairs and were able to decorate and personalise the areas immediately behind them. On Avalon ward, patients had their own

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

bedrooms. On Wisteria ward, most bedrooms were shared by two patients and there were communal bathrooms available. Shared bedrooms had privacy curtains around beds so that patients could have some private space. Patients could personalise their bedroom and there was a range of patient artwork on the walls throughout the ward. The environment was welcoming.

- Bedroom doors on Wisteria had viewing panels. Some patients had no curtain or paper covering these viewing panels. Patients and visitors were able to see clearly into bedrooms. This meant that there was a risk that the dignity and privacy of patients was compromised. Patients said they often went to the bathroom to get dressed, as this gave them the privacy they could not get in their bedroom. During the inspection we saw that one patient bedroom, which looked directly out onto the hospital grounds and which was visible to the public, did not have sufficient privacy film. The lack of proper privacy film on the windows meant that the privacy of the patient was not maintained and meant that people could see into the bedroom from outside. This potentially compromised the dignity and confidentiality of patients using this bedroom. This was fed back to the ward manager at the time who said the film would be replaced.
- On Wisteria ward, there was a whiteboard in the nursing office that contained patient names and was visible to patients and visitors from the ward area. This meant confidentiality of patients was not maintained. This was fed back to the ward manager at the time of inspection.
- Patients from Wisteria ward accessed education on site in separate classroom facilities. These classrooms were shared with two other wards for people under 18 on the same hospital site. The school was staffed by teaching staff supplied by the local authority. The education team delivered full time education provision for patients. The teaching staff were familiar with the health needs of the patient group and adapted the curriculum accordingly. The school had been inspected by Ofsted in 2013 and rated outstanding.
- There was a family suite available on the hospital site where carers and families could stay. This was separate to the ward. There were three bedrooms, a bathroom and a kitchen in this facility. Staff said this was very helpful for people whose families lived far away or who were near discharge. Families and patients could use the area to have unsupported meals.
- Patients had access to mobile phones and could make calls in private.
- On both wards there was a garden that patients could access. The garden on Wisteria ward was kept locked as access had to be supervised due to potential risks. If patients wanted accesss they had to ask staff for access.
- During the current inspection, six patients and three staff said the food was not of good quality. Staff and the patients on the Eating Disorders Day Unit had raised complaints regarding the quality of food in October 2016, at that time the issues had been resolved. However, at the time of the inspection, staff on the unit had identified that the quality had started to decline once again. This was brought to the attention of the trust on the day of the inspection and they took immediate action. The trust had raised a formal complaint with the catering suppliers in February 2017 regarding the quality of the food. The trust met with the patients on Avalon and Wisteria wards on the 3 March 2017 to discuss the issues pertaining to the quality of the food and conduct a full investigation. As a result of the feedback, the trust implemented an action plan to improve food quality. All areas of the action plan were expected to be completed by August 2017.
- Patients were prescribed drinks and snacks in the evening as part of their treatment.
- There were set meal times on the wards. Staff had clear guidance around appropriate food groups, which ensured that patients' calorie intake was monitored. Staff ensured that patients were not allowed to exclude entire food groups unless there was a clinical reason. Staff supported patients during meal times. Staff on the Eating Disorders Day Unit supervised the patients during breakfast and lunch times. Snack times were unsupervised as patients were encouraged to eat healthily and be responsible for ensuring that they maintained their calorie intake. On Avalon ward, patients had voiced concerns during the community meeting that the variety and choice of snacks provided during the morning had been changed without proper consultation. The ward manager had stated that they

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

had limited the range of snacks available because it was taking a long time to prepare individualised snacks for 22 patients and this was impacting on staff being able to provide the therapeutic input to patients.

- Patients on Wisteria ward could store their possessions in safes kept in the nursing office. Staff also kept certain items, which were assessed as a potential risk and gave these out to patients when they required them.
- There was a timetable of activities for patients to attend throughout the week. On Wisteria ward the activities included education, meal times and post meal support groups, therapeutic and activity groups. On the Eating Disorders Day Unit, patients had a range of activities, which included an arts and crafts group, a monthly breakfast club during which patients were encouraged to bring in a different breakfast for everyone to try and a relapse prevention group.

Meeting the needs of all people who use the service

- All services could meet the needs of people requiring disabled access. There was a lift on Wisteria ward to reach the second floor and bathrooms that were accessible. The Eating Disorders Day Unit was on the ground floor and was easily accessible. Both Avalon ward and the Eating Disorders Day Unit had an identified member of staff who was a disability awareness champion. The champion had undertaken specific disability awareness training and was able to provide information to colleagues and patients.
- On the wards and in the Eating Disorders Day Unit, there were several information leaflets available to patients and parent/carers. The staff stated that they believed that this information could be provided in other languages. The information available on Avalon ward and Wisteria did not reflect the diverse needs of the patient group. There was no information in the service for patients who wanted to explore other aspects of their identity or wanted information that was relevant to them. For example, there was no information for patients who identified as lesbian, gay, bisexual or transgender. On the Eating Disorders Day Unit, the staff had ensured that there was information on the men's support group for eating disorders available to patients.
- Staff on Avalon ward supported patients who were religious to access chaplaincy services and an Imam They also had copies of the bible and prayer mats available. The ward had information for staff regarding religious festivals and their dates. However, the information regarding Ramadan and Eid was incorrect. The dates given for these religious festivals was three years out of date. The service did not encourage the patients on the ward to fast due to clinical risk. However, having incorrect written information regarding these religious festivals meant that staff might not support patients appropriately regarding other aspects of these religious festivals they may wish to observe. All three services were able to provide food, which met the religious needs of the patients.
- In all three services, staff could access interpreters, including sign language interpreters if needed. On Wisteria ward, the patient care records highlighted whether an interpreter was needed for the patient.
- The Eating Disorders Day Unit was able to provide transport to patients who were too unwell to use public transport or drive to the service.

Listening to and learning from concerns and complaints

- Information about how to make a complaint was available on Wisteria ward. There were several posters about the patient advice and liaison service, which is a service where patients can provide feedback and make informal complaints about care. The staff member from this service visited the ward weekly and there was an image of them on several posters.
- From March 2016 to February 2017, there had been five formal complaints on Avalon ward, two formal complaints on Wisteria ward and four formal complaints on the Eating Disorders Day Unit. On Avalon ward two complaints had been partially upheld and one complaint had been upheld fully. Both complaints on Wisteria ward had been partially upheld. None of the complaints on the Eating Disorders Day Unit had been upheld. However, one complaint had been referred to the Parliamentary Health Service Ombudsman. At the time of inspection, the review of the complaint had not been completed.
- Managers shared the learning from complaints with staff.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- As well as using the formal trust complaints process, patients were also able to provide feedback through the real time feedback machine on the ward.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Managers spoke with enthusiasm about the values of the trust and how these values underpinned their work. The work undertaken by staff reflected the trusts' vision and values. On Wisteria ward, the trust vision and values were on display throughout the ward.
- Staff knew the senior managers in the trust and some of these managers had visited the service.

Good governance

- There were systems or processes established to ensure the quality and safety of the service was assessed, monitored and/or improved. Staff on the ward made good use of the SiREN reports (which were dashboards reflecting key performance information locally), which enabled the trust to respond to issues of concern on the ward. The information from the dashboards was discussed during the trust's regular governance meetings and data performance meetings.
- The Eating Disorders Day Unit held quarterly operational meetings. Members of the multi-disciplinary team, modern matron and operations manager attended the meeting. The meetings were intended to improve quality, partnership working and innovation.
- The managers had access to these dashboards, which outlined their individual team performance. The dashboard allowed the managers to identify which key pieces of information were missing in care records. For example, if staff had neglected to complete information on child safeguarding this could easily be identified and remedied. The most recent report dashboard for Avalon ward identified that 95% of the care records had the section of child safeguarding completed in full. The dashboard also indicated that three Care Programme Approach (CPA) review letters were outstanding. The ward manager on Avalon ward, reviewed the information on the dashboard on a regular basis and provided feedback to individual members of staff. The manager of the Eating Disorders Day Unit discussed the information on the dashboards during their regular team meetings.
- The managers could easily access information about the overall training and supervision compliance for the whole staff team. The data that was readily available on the dashboard showed the training and supervision rates for individual team members. The managers of the three services received a monthly email about supervision and training from the trust, but could not generate reports themselves.
- Both Avalon and Wisteria ward had risk registers. The Eating Disorders Day Unit did not have one. The risk registers for the wards identified risks relating to the safety and quality of the service. All the risks for the ward were detailed on the register, as were the actions that needed to be taken to mitigate the risks. The trust monitored the progress that had been made against each action. The risk register for Avalon ward included the areas of non-compliance that were identified when the service was inspected in October 2015. The risk register for Wisteria ward, noted the risks that were identified during the CQC Mental Health Act review visit in September 2016.
- After Avalon ward was inspected in October 2015, we said that the trust should ensure they took steps to improve the completion of MEWS charts. During this inspection we found that Avalon ward undertook audits on the completion of MEWS charts. However, these audits were not effective and there were still gaps in the completion of the MEWS charts. There was no clear plans in place to ensure that improvements would be made.

Leadership, morale and staff engagement

- The ward manager for Avalon ward and the modern matron met fortnightly to discuss the ward and identify emerging issues of concern.
- Several staff on Wisteria ward were supported in career progression whilst on the ward. The trust offered lots of opportunities for progression. The ward managers were able to attend monthly ward managers development days as well as nursing conferences and learning disability forums.
- The ward manager on Wisteria ward said the trust were supportive in changes they made in advertising specialist roles.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff on Wisteria ward said they really enjoyed their roles and were passionate about working with young people suffering from eating disorders. Staff morale on the Eating Disorders Day Unit was also high. The staff felt equally passionate about the work they undertook.
- There was information regarding the staff whistle blowing policy on the trust intranet. None of the staff we spoke with said they would have difficulty raising concerns.
- Different disciplines spoke very highly of each other and understood the different roles staff had. The multidisciplinary teams in each service met regularly to discuss patient care and treatment and operational issues.
- The managers of each service were very complimentary about their teams. For example, the ward manager for Avalon ward commented that their theam was supportive of her and each other.

Commitment to quality improvement and innovation

- Wisteria ward were members of the Quality Network for Inpatient CAMHS. This is a peer review network based in the Royal College of Psychiatrist. The service had received a peer review in the two months before the inspection.Avalon ward was accredited by the Quality Network at the Royal College of Psychiatrists
- On Avalon ward, the clinical psychology team was undertaking an evaluation of the therapy group.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way: Information regarding patient's physical health care was not being recorded properly. Information was not transferred promptly on to patients' electronic records Patients' risk assessments were not being updated in a timely manner. The temperatures of fridges used to store medicines were not being monitored in line with trust policy. This was a breach of Regulation 12 (1)(2)(a)(b)(g)