Oak Tree Forest Ltd. t/a Ellern Mede Ridgeway

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Oak Tree Forest Ltd. t/a Ellern Mede Ridgeway as **requires improvement** because:

- Medical and emergency equipment was not checked regularly and the systems in place were not robust enough to ensure that equipment was maintained, clean and fit for purpose. Some emergency equipment, such as defibrillator pads and oxygen masks, had passed the date by which they were safe to use and had not been replaced. Not all actions identified through audit had been completed.
- Naso-gastric feeds were sometimes carried out in the main corridor of Bryan Lask ward as patients could not be safely treated in their bedroom or conveyed to the treatment room. At the time of our inspection this had happened on multiple occasions with one patient. Whilst the provider took steps to maintain the patient's privacy and dignity when this happened, these steps were not always effective and the patient's privacy and dignity were compromised. Patient details and records were visible through the nursing office door on Nunn ward. Patient bedrooms did not provide privacy for patients who were sharing bedrooms.
- At the time of the inspection only female patients were admitted to Bryan Lask ward, however on occasion male patients were also admitted to this ward, the provider was not able to provide a female only lounge which would place them in breach of best practice guidance. Some ward areas were small and felt uncomfortable, for example the dining room and the room used for relatives on Bryan Lask ward. Patients did not have a secure space to store their personal belongings.
- Mandatory training compliance for permanent staff was low at 58%. For bank staff, 79% had not completed mandatory training. After the inspection, the provider confirmed that its mandatory training records were not accurate at the time of the inspection and that by March 2016 permanent staff compliance with mandatory training was 71%, no update was provided for bank staff. Some specialist training, for example the searching of patients and the observation of patients had low compliance rates.
- Whilst all staff were receiving regular group supervision, not all staff were receiving regular one to one supervision.
- The provider did not have effective governance systems in place that effectively monitored the delivery and quality of the service provided. Complaints were not dealt with effectively as the providers system did not acknowledge, investigate and respond to all complainants. The provider had systems and processes in place to monitor staffing levels, individual staff supervision, handling and managing complaints, infection control and clinical equipment. However; the systems in place were not operating effectively. The supervision completion records were not accurate and did not reflect the actual supervision compliance rates. Mandatory and specialist training information was not accurate and did not readily identify staff who required update training.

However:

- The provider was open and transparent in regularly reporting the high number of restraints to the service commissioner and communicating with the local safeguarding team. The use of physical interventions was regularly reviewed and several work streams were in progress to continuously monitor and review the use of restraint to ensure that was used only when absolutely necessary.
- Patient records were clear and included comprehensive admission assessments, risk assessments, behavioural plans, routine capacity assessments and physical health examinations.
- The majority of staff demonstrated a caring and positive attitude and were dedicated to ensuring patients improved and recovered. Patients commented that some staff were caring and that they were able to be involved in planning and reviewing their care. Patients, families and carers were able to give feedback about the service through an annual friends and family test and the results of this survey fed into the development of the service.

Summary of findings

- The provider had completed a joint quality review of the service with Quality Network for Inpatient for Child (QNIC) and Adolescent Mental Health Services CAMHS (CAMHS).
- The service had a large multi-disciplinary team (MDT). On a weekly basis, an MDT discussion took place where patients' care and treatment was discussed. The provider used teleconferencing in order to involve teams that were unable to attend the MDT meetings.

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Background to Oak Tree Forest Ltd. t/a Ellern Mede Ridgeway

Ellern Mede Ridgeway is a hospital in Mill Hill, London. Oak Tree Forest Limited runs the hospital. It is registered to provide eating disorder inpatient services for children and adolescents. The hospital was established in 2011 and provides treatment for up to 26 patients. At the time of the inspection, there were 24 female patients admitted to the hospital, there were no male patients.

The service has three different treatment programmes, provided on two wards and one independent living cottage. Bryan Lask ward offers a high dependency intensive treatment programme for patients with highly complex, challenging or chronic conditions. Patients on the ward have typically been through other eating disorder programmes, which have not resulted in a full recovery. Nunn ward provides a recovery focused programme for patients who are stabilised and require ongoing support. The ward accepts patients who have had previous admissions to other children and adolescent mental health (CAMHS) wards, medical wards and patients who have not been admitted to a specialist eating disorder unit before. The hospital provides an independent living cottage, which gives patients the opportunity to have ongoing support from Nunn ward but live independently alongside other patients.

The hospital has a school on-site equipped to meet patients' educational needs. Ofsted rated the school as outstanding in 2014.

Ellern Mede Ridgeway has a registered manager and undertakes the following registered activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment, for persons detained under the Mental Health Act 1983

We last inspected this service in 2012, 2013 and twice in 2014 when enforcement action was taken against the provider as it was found there was non-compliance against the Care Quality Commission Essential Standards (now Fundamental Standards) which related to a breach of outcome two (consent to treatment) and outcome 16 (assessing and monitoring the quality of service provision). The provider was re-inspected in 2014 when the standards were met.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one assistant inspector, a consultant psychiatrist and a nurse who worked in eating disorders services.

Why we carried out this inspection

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

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?

Summary of this inspection

- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, sought feedback from a range of other organisations and reviewed the information the provider had sent us.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for patients
- visited both wards at the hospital and a separate cottage that provided independent living
- spoke with five patients who were using the service
- spoke with five carers and/or parents
- spoke with the registered manager, senior managers and managers for each of the wards
- spoke with ten other staff members; including doctors, nurses, an occupational therapist, a head teacher and a psychologist
- received feedback about the service from the provider's main referring commissioner
- received feedback about the service from an independent advocate
- attended and observed one patient community meeting
- collected 41 pieces of feedback from comment cards
- looked at 15 care and treatment records of patients
- carried out a specific check of the medication management on two wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

The majority of staff demonstrated a caring and positive attitude and were dedicated to ensuring patients improved and recovered. Patients commented that some staff were caring and that they were able to be involved in planning and reviewing their care. Patients, families and carers were able to give feedback about the service through an annual friends and family test and the results of this survey fed into the development of the service.

Carers and relatives were positive about the service and stated that their relatives received good care at the hospital. Carers told us that they were informed of incidents on the ward when they attended MDT meetings and that the service responded well to any complaints or concerns raised. Relatives and carers told us that their experience could be better when visiting the hospital, for example by providing access to hot drinks. Some families had travelled a long distance and stayed at the hospital for extended periods.

The service thought of ways of involving families and carers in meetings by using teleconferencing. This promoted family involvement and provided opportunities for relatives to have direct input.

However, feedback we received from comment cards and from speaking with patients was mostly negative – particularly in relation to the use of agency staff. Some patients commented that agency staff were not attentive and did not understand their needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- The provider's system for assessing cleanliness and checking medical equipment was not comprehensive and robust. Appropriate checks of medical equipment were not completed on a regular basis, only an adult defibrillator was available for use in an emergency and the pads on this piece of equipment had expired in 2013 and had not been replaced. The emergency oxygen supply was equipped with an out of date face mask that had not been replaced. This increased the risk of patients not receiving appropriate life support in an emergency.
- Not all actions identified through infection control audits had been followed through. Records showed actions from an annual infection control audit that took place in June 2015 had not been completed. For example, there was not a system in place for staff to routinely check and record fridge temperatures in the OT kitchen where food was stored.
- The provider had not ensured that all staff had completed mandatory training. At the time of the inspection, the overall compliance rates for mandatory training were 58% for permanent staff. For bank staff, 79% had not completed mandatory training. After the inspection, the provider acknowledged that its mandatory training records had not been accurate at the time of the inspection and advised that from March 2016 mandatory training compliance for permanent staff was 71%, no update was provided for bank staff. The provider could not be sure that its training record system was clear and up to date.
- Bryan Lask ward provided care and treatment to male and female patients. The ward did not include a female only lounge. At the time of the inspection, the provider was not in breach of same-gender accommodation guidance as only female patients had been admitted. However, if male patients were admitted to the ward, a female only lounge would need to be provided to ensure the provider was not in breach of guidance.

However;

- Risk assessments were up to date and provided a clear management plan. Risk was assessed on admission and reviewed on a weekly basis by the multidisciplinary team.

Summary of this inspection

- The provider recognised that the incidence of physical interventions was high and that they were reviewing how they carried out physical interventions. Several work streams were in progress to continuously monitor and review the use of restraint to ensure that it was used only when absolutely necessary.
- The hospital had appropriate medical cover in place for out of hours support. A consultant and speciality doctor could be contacted as required. A senior nurse was on call out of hours to provide support to staff.

Are services effective?

Good

We rated effective as **good** because:

- We reviewed 15 care records and all records demonstrated that the patient was assessed comprehensively on admission including a physical health examination. Patients received on-going physical health monitoring. Care plans were up-to-date and mostly demonstrated personalised and holistic care. Care Programme Approach (CPA) meetings were scheduled every eight to 12 weeks and included patient views and the multidisciplinary (MDT) team.
- The provider demonstrated that they were providing care and treatment in accordance with guidelines. The provider was ensuring that patients' physical health was being monitored routinely including cardiac monitoring and regular blood tests. There was access to a paediatrician who visited the hospital regularly and patients were monitored closely in relation to refeeding syndrome (a physical complication that occurs when food is reintroduced) and dietary intake.

  The provider used various outcome measure tools in order to demonstrate treatment effectiveness. The service provided national institute for health and care excellence (NICE) recommended psychological therapies. Therapies included cognitive behavioural therapy, dialectical behavioural therapy, family therapy and art therapy. Therapies were offered on an individual and group basis and were tailored to individual needs.
- Staff we spoke with had a good understanding of the main principles of the Mental Health Act (MHA) and were able to apply their knowledge to everyday practice. MHA detention paperwork was organised and completed accordingly.

However,

Summary of this inspection

- The provider had not prescribed medicines and managed medicines in accordance with the medicines management policy. Medicines prescribed in special circumstances that were not licensed for young people and children had not been clearly documented in the patients care record.
- The provider did not hold accurate up to date information relating to specialist training for staff. This meant the provider could not be sure that staff had received specialist training appropriate to their role or that all that staff on duty had an appropriate skill mix. For example staff had not been trained in carrying out physical searches on patients or their property or in observing patients.
- One to one clinical supervision was not always happening on a monthly basis but staff were receiving regular group supervision.

Are services caring?

Good

We rated caring as **good** because:

- The majority of staff demonstrated a caring and positive attitude and were dedicated to ensuring patients improved and recovered. Patients commented that some staff were caring and that they were able to be involved in planning and reviewing their care. Patients, families and carers were able to give feedback about the service through an annual friends and family test and the results of this survey fed into the development of the service.
- Carers and relatives were positive about the service and stated that their relatives received good care at the hospital. Carers told us that they were informed of incidents on the ward when they attended MDT meetings and that the service responded well to any complaints or concerns raised. Relatives and carers told us that their experience could be better when visiting the hospital. Some families had travelled a long distance and stayed at the hospital for extended periods.
- The service thought of ways of involving families and carers in meetings by using teleconferencing. This promoted family involvement and provided opportunities for relatives to have direct input.
- When an incident took place, patients that were involved or witnessed the incident had opportunities to debrief in one to one sessions with staff.

However,

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- Some patients did not feel that staff engaged fully with them. This was reflected in complaints made to the provider, some of which commented that staff were not attentive.

Are services responsive?

Requires improvement

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

- The provider was not consistent in their approach to handling and responding to complaints. Complaints demonstrated a lack of sympathy towards the complainant and responses and acknowledgement letters were delayed. Some complainants did not always receive an acknowledgement letter. Fifty percent of complainants had not received a response to the complaint they had made. The hospital had not ensured they were working in accordance with the provider's policy.
- Naso-gastric feeds were sometimes carried out in the main corridor of Bryan Lask ward as patients could not be safely treated in their bedroom or conveyed to the treatment room. At the time of our inspection this had happened on multiple occasions with one patient. Whilst the provider took steps to maintain the patients privacy and dignity when this happened, these steps were not always effective and the patients privacy and dignity were compromised Where patients shared bedrooms, dividing curtains to promote privacy and dignity had not fitted. Patient personal details were in view through the glass panel on the nursing office door on Nunn ward, which compromised patient confidentiality.
- Some ward areas were small and felt uncomfortable. Patients on Bryan Lask ward had access to a quiet room. However, Nunn ward did not provide a quiet room. Bryan Lask ward used the quiet room as a relative's room but there was enough seating to accommodate more than two people. On Nunn ward, the dining room was small and we observed that patients were not comfortably accommodated during mealtimes. Patients did not have a secure space to store their possessions.

However,

- The service had a large scenic garden, which provided outdoor space for patients to use. The provider ensured that carers and families were involved in the care of the patient and patients were able to feedback their opinions and thoughts.
- Patients had access to a comprehensive education timetable. There was a school on-site and the school staff gave routine feedback to the hospital about patient progress.
- The provider had made adjustments for people that required disabled access. Patients had access to a disabled toilet and

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bathroom on Bryan Lask ward. The provider accommodated patients with reduced mobility in a bedroom with en-suite facilities. Patients that were nursed in bed had access to entertainment through the ward ipad and were encouraged to access the communal areas for the television.
- Leaflets were available to patients and could be supplied in languages other than English if required.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The provider had systems and processes in place to monitor staffing levels, individual staff supervision, handling and managing complaints, infection control and clinical equipment. However; the systems in place were not operating effectively. The supervision completion records were not accurate and did not reflect the actual supervision compliance rates. Mandatory and specialist training information was not accurate and did not readily identify staff who required update training. Some actions identified from audits had not been completed. Systems to check emergency medical equipment were not effective and the provider's complaints procedure was not robust.

However,

- Overall, staff morale was good and staff felt supported by their manager and the wider MDT in their roles. Staff told us that they felt the team worked well together and that everyone was able to share their opinion. The provider gave staff an opportunity to regularly feedback via the staff survey.
- The provider welcomed quality visits from the Quality Network for Inpatient for Child (QNIC) and Adolescent Mental Health Services CAMHS (CAMHS) and had jointly completed a quality review.
- The provider had created a quality assurance framework, which included 10 priorities for 2015 to 2016. The priorities were being completed and the provider had a plan of how these would be achieved.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Ninety percent of permanent staff had completed training in the Mental Health Act 1983 (MHA) and the Code of Practice 2015. Staff had received MHA training and demonstrated a good understanding of the main principles. However, a small number of staff were less sure in their understanding of the MHA and code of practice.

For patients that were detained under the MHA, their rights were regularly explained to them and were recorded in the patient record. The MHA was used appropriately and detention documentation complied with the MHA and code of practice. The provider had support from mental health act administrators who based within the hospital. The administrators completed audits to ensure that all aspects of the MHA were applied appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that only 52% of staff had completed mandatory training in capacity and consent. The Mental Capacity Act 2005 (MCA) applies to people who lack capacity to make some or all of their own decisions. Some staff did not have a good understanding of assessing capacity and using Gillick competency and parental consent, others were more confident. Staff told us that if they were unsure about a patient's capacity they would seek guidance and support from senior staff.

The provider had an MCA policy, which was up to date and reflected current legislation and case law. The MCA does not apply to children under the age of 16. For these children the service considered Gillick competency in deciding if the young person could give consent or if parental consent was required. Records demonstrated that capacity and competencies were assessed regularly and documented appropriately in patient records. Some patients were admitted to the hospital under parental consent. This meant that children that lacked competence and young people who lacked capacity, were admitted to hospital and treated based on parental consent. Care records demonstrated that parents had signed forms to confirm that they had agreed to medication, physical interventions and NG feeding if required.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

- The service had two wards, Bryan Lask and Nunn and a cottage on the same site. Both wards were locked; the cottage was not locked as it was used to provide accommodation for patients who were preparing for discharge. The patients in the cottage were able to use Nunn ward facilities.
- The layout of Bryan Lask and Nunn wards meant that staff did not have a clear line of sight to observe patients in all areas of the ward. However, staff were deployed in communal areas of the ward, which appropriately mitigated this risk. In addition, the majority of patients were continually supervised due to their assessed risk.
- The service did not have seclusion facilities. Patients were not nursed in seclusion or segregated.
- The provider had appropriate arrangements in place to manage ligature points. A ligature point is a place to which patients intent on self-harm might tie something to harm themselves. The hospital environment had a number of ligature anchor points on Bryan Lask and Nunn wards. An annual ligature risk audit for both wards was completed in March 2015. Ligature point risks were mitigated by enhanced staff observation, supervised use of some rooms and individual risk assessment. We observed many staffin the communal areas supervising patients and carrying out one-to-one observations. The audit highlighted areas that required urgent attention and a completion date had been set for outstanding works to be completed. A number of ligature points had been identified in ward bathrooms. The risks of self-harm were mitigated by the provider undertaking works to remove these. These works had not been completed and in the interim, patients assessed as being at risk of fixing a ligature were supervised whilst using the bathroom. Their privacy and dignity were promoted by the use of a screen between the patient and supervising staff.
- Some works had been undertaken within the cottage to reduce the number of ligatures, including the replacement of door handles with anti-ligature fixtures. The audit for the cottage indicated that some ligature points remained. In addition, the provider had identified that a member of staff should be present in the cottage at all times to further mitigate the risk. Ligature cutters were accessible to staff on both wards. However, the cottage did not have ligature cutters available. Patients placed at the cottage were identified as having lower support needs and were preparing to move on from the hospital. Each patient was risk assessed prior to their move from the ward to the cottage and staff were present within the cottage at all times.
- The provider had a resuscitation policy available. A 'chain of survival' diagram was included in the policy and was available in the clinic rooms.
- Bryan Lask ward provided care and treatment to male and female patients. The ward had one single bedroom with an en-suite bathroom, which could be used by a male patient. This was in accordance with national guidance for mixed-gender accommodation. However, there were no facilities to provide a female only lounge. At the time of the inspection, the provider was not in

breach of same-gender accommodation guidance as only female patients had been admitted. If male patients were admitted to the ward, a female only lounge would be required.

- In the main reception area of the hospital, there was a list of senior staff that were available during the day indicating the fire marshall and the first aider.
- The emergency equipment including the defibrillator was stored in a treatment room on Bryan Lask ward, which meant that if the treatment room was in use it would not be readily accessible from either wards clinical room, or the cottage. Our checks of the emergency equipment showed that an adult defibrillator was available as part of the emergency equipment. Its pads had expired in 2013. This was raised with the ward manager and the pads were changed during the inspection. A child defibrillator was on order and the provider planned to make this available in addition to the adult defibrillator. The impact of the wards not holding the appropriate equipment for the patient group increased the risk that in an emergency a patient would not receive appropriate life support. The oxygen mask within the emergency bag had expired. We raised this with the ward manager who arranged for it to be replaced. Clear procedures to show staff what to do in an emergency was documented within the provider's resuscitation policy. Weighing scales in the clinical room had been serviced. Equipment to check patients' blood pressure, pulse and temperature were available. Checks of clinical equipment by staff were not robust as they had not identified the expiration of the defibrillator pads or oxygen mask. The records completed by staff who had undertaken these checks were annotated as "compliant" when they were not. The treatment room on Bryan Lask ward did not have an examination bed.
- Nunn and Bryan Lask ward were stocked with basic emergency medicines. The cottage did not hold emergency medicines but staff from either ward would take the emergency equipment including the medicines to the cottage when attending an emergency. The provider did not stock secondary emergency medicines and had consulted with the contracted pharmacist to assess the need. The provider took the decision that the medicines were not required in a service of this kind and emergency services would be contacted in an emergency. The external pharmacy company monitored and reviewed the emergency drugs regularly. Nunn ward stocked anaphylaxis kits and allergy related injections.
- Both wards and the cottage were visibly clean and free from clutter. The service employed a team of cleaning staff. The provider had recently introduced new documentation for staff to record when cleaning was completed and advised that from March 2016 onwards this documentation would be regularly audited to ensure that identified cleaning tasks were completed and signed off.
- The provider had developed some infection control systems but these were not robust. An infection control audit that was completed in June 2015 stated fridges in the occupational therapy (OT) kitchen should have their temperatures monitored and recorded as the fridges stored food. During the inspection, the OT fridge temperatures were not being checked and recorded. The lack of food temperature checks posed a risk to patients as the provider could not be sure that food stored within the OT fridge was safe to be eaten. The service had a designated infection control lead. The lead had recognised that the system in place to report infection control concerns or incidents was not sufficient, as there was only one member of staff to whom issues could be reported. The providers' infection control policies and procedures were being updated, as they were not comprehensive. Infection control audits were completed and covered many areas, including cleanliness, food hygiene and hand hygiene. Handwashing posters were visible on the walls around the hospital.
- The wards did not have an integrated alarm system in place, which meant that bedrooms were not fitted with call alarms. This meant that patients who required support in their bedrooms when unaccompanied by staff, would need to call out to attract staff attention. Staff were not provided with personal alarm systems. Staff we spoke with felt safe on the wards. However, patients and staff were at risk, as there was no way of alerting others that assistance was required. The provider had identified this as an area of concern and was in the process of commissioning an integrated call alarm service.

- There were fire evacuation procedure notices visible on the ward corridors. The provider had completed weekly fire drills over the past three months.

Safe staffing

- Overall, the provider maintained safe staffing levels on the wards and the cottage. However, the provider relied heavily on bank and agency staff to cover vacant nursing posts. Bryan Lask and Nunn wards employed 15 permanent registered nurses and 52 healthcare assistants (HCAs). Staff from Nunn ward also staffed the cottage. The hospital had seven vacant nursing posts and eight healthcare assistant posts. Recruitment and staffing was regularly reviewed in monthly quality safety meetings and the provider was actively recruiting via their website and via health professional agencies. The January 2016 quality safety meeting minutes showed that regular updates were planned for the nursing operations meeting (NOMs) on recruitment and retention.
- A safer staffing model had been introduced over the previous four months and the provider acknowledged that the model required further embedding into practice. The provider had identified there was high use of agency staff working on the wards and there was a need to ensure consistency for the patients. The model aimed to manage staffing levels based on patient activity and need.
- The hospital were using a high number of agency and bank nurses to cover enhanced patient observations as well as vacant posts. For example, in January 2016, bank and agency staff covered 33% of day shifts. In February 2016, agency staff covered 31% of day and night shifts combined. Ward managers were able to increase staffing when required and regular agency and bank staff were deployed to ensure consistency. Senior managers were available to attend to the ward if there was a staffing shortage and patients were familiar with them. On one occasion in recent months, the only nurse on duty was from an agency. The provider had increased the number of healthcare assistants (HCAs) on the ward on these days to ensure that staffing levels were safe. This had an impact on patients as some felt they were not listened to by agency staff and that they did not understand their needs. However, activities were rarely cancelled and patients had regular sessions with the occupational therapist and activities coordinator.
- Bryan Lask ward had two nurses and four HCAs during the day shift and an additional five staff for specific patient observations. On Nunn ward, the nursing levels were two registered nurses and five HCAs. The ward did not have extra staff for carrying out patient observations, as this was not required for the patient group. Two nurses covered the night shifts, one on each ward. On Bryan Lask ward, the night shift included three HCAs and an additional four members of staff for specific patient observations. On Nunn ward, the night shift included four HCAs. A member of staff from this establishment was allocated to the cottage. Ward staffing levels were reviewed on a daily basis and a staffing report was completed at the end of every shift to demonstrate the actual staffing numbers. The forms were reviewed by a senior nurse and monitored in daily nursing meetings with senior management.
- Bryan Lask ward was a high dependency unit providing care and treatment to patients with high levels of acuity and complexity. For the preceding six months, the provider had employed an external nursing restraint team on Bryan Lask ward to manage complex restraint interventions. The provider had identified that ward staff had been under pressure from the high number of physical interventions with patients and had determined that the deployment of a specialist physical intervention team was the most appropriate approach to manage the situation. This approach had been discussed and agreed with service commissioners. A consistent core group of staff made up the physical restraint team. Some of the staff deployed within the physical intervention team were sometimes additionally rostered on duty as part of the general staffing complement. Some patients commented that they found it difficult to build rapport with staff deployed on general duties within the ward when their main contact with them previously had been through the physical intervention team. The provider had reviewed the use of the physical intervention team and planned for permanent staff on Bryan Lask ward to integrate into the physical intervention team, however, there was no timescale attached to this plan.
- Appropriate medical cover was available out of hours and at the weekends. A consultant and speciality doctor could be contacted as required. A senior nurse was on call out of hours to provide support to staff.
- The provider acknowledged at the time of inspection that the training records did not accurately reflect

mandatory training compliance rates. The data available at the time showed that overall mandatory training compliance rate for permanent staff was 58%. The areas of poor compliance were breakaway training, conflict resolution, physical intervention and safeguarding. The training compliance rate for bank staff demonstrated that 79% of staff did not have up to date mandatory training. The areas of the highest non-compliance were safeguarding, basic life support, conflict resolution, physical intervention and infection control. The provider's restraint lead facilitated in house physical intervention training for staff. Staff told us that restraint was used as a last resort and were able to describe various de-escalation techniques that were used. After the inspection, the provider advised that the mandatory training compliance rate for permanent staff was 71%, no update was provided for bank staff.

- The provider acknowledged that training was a concern. In addressing this issue, the provider had discussed and reviewed training at quality governance meetings over the previous three months. A training calendar was used to plan and book staff onto upcoming training, with some additional sessions scheduled. However, a target time for all staff to have completed mandatory training had not been established. The provider had introduced a training and revalidation project.
- The provider expected the supplying agency to ensure that agency staff were trained in physical interventions. However, the provider was unclear whether this training addressed the specific needs of children and young people with an eating disorder. Senior staff acknowledged that some staff were performing physical interventions that differed from the provider's policy. As a result, the service was developing plans to provide physical intervention training to all agency staff to ensure consistency of approach when de-escalating situations or using physical interventions. However, no date had been fixed for when this training would be provided to agency staff.

Assessing and managing risk to patients and staff

- Between August 2015 and January 2016 there had been a high number of restraints. There had been 2052 occasions where restraint was required. None of these incidents of restraint resulted in patients being held in a prone position. Patients who were admitted to the hospital were highly complex and some patients presented with behaviours that challenged. Of the restraints, 1224 incidents related to planned physical intervention associated with nasogastric (NG) feeding. Bryan Lask ward carried out the highest number of restraints as the patients on the ward declined food or NG feeds. In order to ensure patients reached and maintained a healthy body mass index (BMI), patients required physical interventions during NG feeding. There had been 28 incidents of unplanned physical intervention required.
- Overall, the 15 care records reviewed included up-to-date risk assessments. All patients were assessed on admission and reviewed on a weekly basis by the multidisciplinary (MDT) team. For patients who self-harmed there were risk assessment and management plans in place to manage this on the ward. There were deescalation plans in place tThe provider did not have an electronic care records system and acknowledged this was an area for improvement. The provider had included the need for upgraded systems for care records on their risk register.
- The highest number of physical interventions took place on Bryan Lask ward. The incidents had involved different patients. However, there was a high number of incidents that involved three particular patients. Patients who regularly required physical interventions had positive behaviour support plans and comprehensive care plans in place that were person-centred. There was evidence to demonstrate the patient was involved in the care planning stage. Care records demonstrated contingency plans and anger management plans were in place. We saw a good example of person centred care, where the patient had outlined the de-escalation techniques that worked best for them and staff followed these. Care records evidenced that the provider had included second opinions from external experts that was included in most management plans.
- The provider monitored physical interventions and was working closely with commissioners who monitored the use of physical interventions. The provider recognised that the incidence of physical interventions was high and that they were reviewing how they carried out physical interventions. Several work streams were in progress to continuously monitor and review the use of restraint to ensure that it was used only when absolutely necessary.

- The provider had an up to date physical intervention policy and procedure, which included required training, defined types of restraint and how to carry out restraint appropriately. Staff were aware of using the least restrictive intervention. The policy provided information about warning signs, response strategies and use of restraint. After every physical intervention, staff were expected to complete an incident form which detailed how the intervention was carried out. The provider's policy and procedure stated that patients and staff involved in the restraint should be debriefed after each incident.
- We reviewed five restraint incident forms and the de-escalation record book. The physical intervention forms demonstrated that staff were carrying out physical interventions appropriately and documented the use of de-escalation techniques before physical interventions were used. Patients subject to physical interventions and staff involved in physical interventions were debriefed following the incident. Parents were also included within the debrief on occasion.
- Incident forms, including incidents of restraint, were reviewed in daily nursing operations meetings.
- Training records demonstrated a poor take up of safeguarding training. Seventy percent of permanent and bank staff did not have up-to-date safeguarding of vulnerable adults and children training. In response, the provider had identified 40 staff to complete this training as a priority. Additional safeguarding training sessions had been scheduled to deliver this training. After the inspection, the provider sent us safeguarding training rates for permanent staff, which demonstrated that by March 2016, 91% of permanent staff and 25% of bank staff had completed an update. Nine out of 10 staff that we spoke with demonstrated a good understanding of safeguarding and their responsibilities. One member of staff was less confident. However, all staff told us that they would discuss any concerns with their manager and the hospitals safeguarding lead. The provider had a safeguarding policy in place, which clearly outlined different types of abuse, the procedure for reporting and how to document a disclosure. The policy included guidance on child protection plans and the safeguarding training that was required for staff. The provider had sought advice from the local authority safeguarding team when required. Where safeguarding alerts had been raised with the local authority safeguarding team it was demonstrated that the provider had worked in partnership with other agencies to investigate the concerns and took appropriate action to safeguard the patient. Safeguarding concerns were reviewed at the nursing operations meetings and the outcome of concluded safeguarding investigations was fed back to staff.
- On both wards, there were signs informing patients that they were not allowed to remain in their bedrooms during the daytime. This was because the provider encouraged patients to leave their bedrooms during the day and to engage in ward activities and attend the school programme.
- On Bryan Lask and Nunn wards the entrance doors were locked, which meant that informal patients were unable to leave the ward freely. However, there were signs displayed on the wards, which informed informal patients of their rights. Senior managers acknowledged that when an informal patient requested to leave the ward, the patient's age and risk was taken into account. Staff contacted the patients' parents or carers if appropriate to gain parental consent. Patients were encouraged to go out with a member of staff.
- An external pharmacy company attended on site and provided support to the wards. Pharmacists visited regularly and replenished stock. The external pharmacist reviewed the medicine administration charts weekly and any errors or issues identified were actioned and fed back to the provider's governance meeting every three months.
- The provider had safe procedures in place for when children visited the hospital. A visitor's room was available near the main reception. On Bryan Lask ward there was a specific relatives rooms. However, the room was cramped, had minimal seating and was not child friendly.

Track record on safety

- No serious incidents had occurred in the past 12 months.

Reporting incidents and learning from when things go wrong

- Staff knew what kind of incidents should be reported and alerted the relevant members of staff. However, incidents were not always reported and investigated appropriately. On one occasion in the past four months,

a patient had made an allegation about a member of staff. The provider had not followed its own policy and procedure. The provider had reviewed all incidents over a five-month period. This review demonstrated that the highest number of incidents that had been reported were largely related to self-harm and physical aggression towards staff. These type of incidents were directly related to when patients were fed naso-gastrically. There had been a lack of consistency in reporting incidents as on some occasions the incorrect form had been used. Clarification had been provided to staff regarding the correct use of forms and the providers review found that accurate incident reporting had since improved. Incidents were reviewed in daily nursing operations meetings. Meeting minutes demonstrated that ward managers were following up incidents.

- A review of incident reports demonstrated that in the months of August, September and October 2015 patients were breaking out of a restraint hold. The provider had also recognised this trend and taken appropriate steps to address it. A review of more recent incident records showed that there had been a reduction in this type of incident.
- Feedback from incident investigations was discussed in nursing operation meetings (NOMs) and with staff on the ward.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Comprehensive and timely assessments were completed on admission. Fifteen patient records were reviewed; they demonstrated that each patient had been assessed on admission, which included a comprehensive physical health examination. Patients received on-going monitoring of physical health checks and blood investigations took place, the results of which were communicated to the team consultant.
- Staff developed care plans with patients on admission. The records were detailed and clearly stated how the staff would meet the patients' needs. Care plans were regularly reviewed and were personalised. Patients received a copy of their care plan. However, one record we looked at showed minimal or no involvement of the patient and demonstrated a lack of focus on goals for the patient to work towards during their admission. Care Programme approach (CPA) meetings were scheduled every eight to 12 weeks and multidisciplinary meeting (MDT) reviews took place on a weekly basis. All meetings were appropriately documented.
- The provider used paper based patient record systems. Information was readily available and stored securely within the nursing office. Each nursing office had a locked cupboard where patient records were stored.

Best practice in treatment and care

- The national institute for health and care excellence (NICE) guidelines was not being met in relation to the management and prescribing of medication. The provider had not clearly documented in the clinical notes where medicines were prescribed for children that were only licensed for adults (off-license). The prescribing clinician had not demonstrated that the family had been informed. Medicines were prescribed in this way to children in special circumstances. The provider was not working in accordance with its own medicines management policy and procedure.
- The provider had used the Royal College of Psychiatrists junior marsipan guidelines (2014) in relation to the care and treatment of patients. The provider was ensuring that patient's physical health was being monitored routinely including cardiac monitoring and regular blood tests. The provider was monitoring patients closely in relation to refeeding syndrome and dietary intake.
- The provider offered NICE recommended psychological therapies to patients with an eating disorder. The service offered a range of therapies including cognitive behavioural therapy, dialectical behavioural therapy, family therapy and art therapy. Therapies were offered on an individual and group basis. Therapies were tailored to individual needs and patients were reviewed on a weekly basis. Group therapy sessions rotated every 10 to 12 weeks.

- Patients' nutrition and hydration needs were assessed regularly. Four meal plans were reviewed which demonstrated that patients were given a choice. The wards provided a snack choice from specific lists, which were matched to the patients agreed food intake.
- The provider had access to a specialist consultant paediatrician when required. The provider accessed the local general hospital for emergencies.
- The provider used four recognised rating scales in order to assess and record individual patient outcomes. Staff documented outcome scores within patient records and the data was collected on admission and at the point of discharge. Staff gathered information about patients to assess whether they had made positive changes as a result of treatment. Seven patients had been discharged in between October and December 2015 and the results showed that they had made good progress in their treatment. Upon discharge seven patients had declined to complete the eating disorder examination questionnaire (EDE-Q); therefore, this particular rating scale could not always be used to measure clinical effectiveness. However, the provider was still able to gather data using its other outcome measures.
- A clinical audit team carried out regular audits, including infection control, care records and training audits. The quality governance meeting minutes evidenced that the findings from audits had been presented to the senior management team.

Skilled staff to deliver care

- A range of specialist training was available; however, take up of this was variable and specialist training records were not always up to date. The provider's quality governance meeting minutes demonstrated that training was regularly discussed and there had been a positive uptake of some specialist training which included taking blood and electrocardiogram (ECG) monitoring. Training records demonstrated that three permanent members of staff had completed phlebotomy training. However, training records did not demonstrate that all specialist training records had been updated which meant that the provider was not documenting and recording compliance rates appropriately.
- Staff were provided with awareness training around eating disorders and the principles of naso- gastric (NG) feeding during the providers formal induction. During the inspection, the providers training records demonstrated that 54% of nurses had received specialist nasogastric-feeding (NG) training. The provider told us that they provided nurses with different levels of training and only senior staff nurses were able to administer NG feeds. In addition to the training, senior nurses were required to undertake specific in house training and mentoring. After the inspection, the provider advised that 71% of senior nurses had received training in order to administer NG feeds and that one of these trained nurses was always present during NG feeds. The provider acknowledged that the training records were not clear and did not capture accurate training compliance rates. The provider stated that it expected the supplying agency to ensure that agency staff had completed this training, but that there was no formal mechanism to confirm this with agency staff when staff arrived on shift. We reviewed six NG feed charts, which had been completed comprehensively and included important details about the feed. For example, type of feed, the volume of the feed, where the tube was inserted, pH (a scale to measure acidity of a solution) readings and the staff that were involved.
- The provider had an observation policy and which stated that staff should be trained in the use of observation and searching of patients, however this was not mandatory training and was completed during staff induction. Training records demonstrated that only 3% of clinical staff had undertaken observation training. The lack of training increased the risk of staff not being equipped with the knowledge in order to carry out patient observations. However, training sessions had been booked for staff to complete throughout 2016. The provider had a comprehensive search policy in place; however, staff had not been trained in how to carry out searches appropriately.
- All staff received an induction. However, as the provider ran induction programmes every four months, there could be delays in some staff completing their induction in a timely manner.
- All staff regularly attended group supervision with their peers and ward managers told us that staff regularly asked to meet with them privately. This was not included within the supervision data recorded by the provider. At the time of inspection, supervision records demonstrated that in December 2015, only one member of staff had received supervision on Nunn ward. Between January to March 2016 on average 43% of all permanent staff on Bryan Lask and Nunn ward had

received one to one supervision. After the inspection, the provider had advised us that from October 2015 to February 2016 the average supervision rate for nurses on both wards was ward was 67%. The senior manager was managing supervision rates through an electronic system where data was collected.

- Ninety seven percent of non-medical staff received an appraisal in the previous 12 months.
- Ten staff employment records files were reviewed. All demonstrated that a disclosure and barring service (DBS) check and had two references from previous employment had been obtained. However, two files did not contain an application form and a probationary review. This issue was raised with a senior manager who had advised that these documents were available and were currently with the personnel department.

Multi-disciplinary and inter-agency team work

- The MDT included psychiatrists, a paediatrician, nurses, occupational therapists, a range of therapists including an art therapist and systemic family therapists, a psychotherapist, psychologists', a dietician and a dietetic technician, research assistants and a social worker.
- The ward managers and senior managers attended a daily nursing operations meeting (NOMs). The meetings had a set agenda and included staffing, incidents (including physical interventions), training and patient feedback. The meeting was open to all clinical staff; however, meeting minutes demonstrated that nurses from the wards rarely attended due to demands of the wards. The wards did not have dedicated team meetings. Staff told us that information from other meetings such as the NOMs meeting was fed back to them through daily handovers and through fortnightly reflective practice meetings.
- On a weekly basis the wards had an MDT discussion where all patients were discussed. The meeting provided an opportunity for patients to be reviewed by all staff that were involved in the patient's care and treatment. The meeting reviewed risk, overall presentation and incidents. The provider arranged Care Programme Approach (CPA) meetings every six to 12 weeks. The CPA documentation demonstrated a thorough discussion of risk, joint working with the patient, external community teams and the patient's family or carer. The provider used teleconferencing in order to involve teams that were unable to attend the MDT meetings.
- Nunn ward and Bryan Lask ward had two handovers per day. The nurse in charge handed important information to the next shift, which included the overall presentation of the patients including risk and meal plans.
- The service had an on-site school, which provided education to the patients on the wards. The teachers at the school worked closely with the MDT and provided a weekly report. The report informed the clinical staff of the patient's overall presentation and engagement. The teachers at the school worked jointly with the safeguarding lead for the hospital. Each patient was allocated a key-worker who was involved in the patient's individual education timetable.
- The provider had developed effective working relationships with the local authority. Commissioners visited the service each month and were involved in discussions regarding individual patient care and the overall performance of the service.

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

- Ninety percent of permanent staff had completed training in the Mental Health Act. Fifty-five percent of bank staff had completed this training.
- We spoke with six members of staff about the main principles of the MHA and code of practice. Five members of staff had a good understanding and were able to explain how the act applied in practice.
- For patients that were detained under the MHA, their rights were explained regularly, with this recorded in their care and treatment records.
- Twelve care records were reviewed for patients that were detained under the MHA. All of the records showed that detention paperwork was completed correctly, up to date and stored appropriately. The provider had appropriately completed consent to treatment forms and for patients that were admitted to the service under parental consent, MHA paperwork was not required.
- The provider had an appropriate MHA administration policy and a policy for patients that were detained under the act. The policies included guidance on involving an advocate and guidance on completing MHA paperwork correctly.

Requires improvement

Specialist eating disorder services

- The on-site Mental Health Act administrator supported the wards. The MHA records were held centrally and ward staff could contact the team for advice and support. The provider carried out audits to ensure that the MHA was applied appropriately. The audit included a review of detention paperwork and ensured expiry dates were reviewed.

Good practice in applying the Mental Capacity Act

- The provider offered two different capacity-training programmes during induction, which included mental capacity act (MCA) training and consent and capacity. The training records showed that 52% of staff had completed refresher training in capacity and consent. This was a low figure. Twenty percent of staff had completed refresher training in the MCA. Ten members of permanent staff had been booked onto the two training programmes in the past three months. The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16, staff applied Gillick competency. This recognised that some children might have a sufficient level of maturity to make some decisions for themselves. Patients' records contained information that related to capacity and consent. The understanding of Gillick competency amongst the staff group varied as some staff were more confident than others in describing how to apply the guidance. Staff were clear that if they were unsure they would speak with a senior member of staff to clarify. Staff gave us examples of assessing capacity around medicines. Competency was considered on a weekly basis at the MDT meeting. Assessments included consent for admission, treatment and NG feeding.
- The provider did not use deprivation of liberty safeguards (DoLS) as the patient group were under the age of 18.
- The provider had an MCA policy, which was up to date and reflected current legislation and case law. Guidance for staff on Gillick competency and capacity for young people that were under 16 was also available.
- Overall, patient records demonstrated that capacity had been assessed and recorded appropriately. The MDT discussed capacity on a weekly basis and discussions were clearly documented. The dietician discussed NG feeding with individual patients, their relatives and carers as well as a joint decision made with the MDT. Gillick competence was assessed on a weekly basis by the medical team.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

- We observed mixed interactions between staff and patients. Some staff spoke to patients in a kind and caring manner and others did not engage in conversation. Patients told us that some staff were polite and some staff were not approachable.
- Patients that were being nursed in bed told us that they were bored and wanted increased access to the internet and television on the ward. The provider encouraged patients to access entertainment through the ward ipad and to watch the television in the communal areas of the hospital.
- Some patients told us that they felt that staff did not want to engage or interact with them after they had been involved in an incident on the ward and that this was because they did not understand their needs. However, none of the patients we spoke with had raised this with the provider as an issue. Staff told us that patients had individual keyworkers who they were able to speak to and they were able to raise any comments or concerns to the wider MDT meeting.
- Patients we spoke with told us that there were some agency staff working on the wards and that they were unsure of who staff were. A common theme that ran throughout the patient community meeting minutes was that patients had noticed staff using their mobiles and the internet on the ward for personal use. Patients on Bryan Lask ward commented that there was a lack of female staff on the wards. However, the staff rota did not demonstrate this.

The involvement of people in the care they receive

- Staff clearly documented patient views within care plans. Patients did not attend the regular MDT meetings, which was a considered clinical decision made by the

provider. Patients contributed to their care plans prior to the meetings taking place. The MDT were involved in meeting with patients to feedback information from the MDT meetings and to discuss their care. Medical staff spoke with patients on an individual basis. Staff asked patients to write down their views and the key nurse would communicate this to the wider MDT. Staff documented patient views in a specific of the care record. MDT meeting minutes demonstrated that the team had discussed patient and carer feedback.

- Patients had access to regular ward community meetings where they were able to ask questions and raise any concerns. Governance meeting minutes were reviewed from September 2015 to February 2016, which demonstrated that patient feedback was discussed. A member of the senior management team attended each community meeting to provide feedback on concerns and issues previously raised by patients. After the inspection, the provider sent us an annual review of all patient feedback they had received.
- The provider gave carers, parents and patients an opportunity to feedback about the service. The provider carried out a family and friends test (FFT) in December 2015. However, not all patients, parents or carers had participated. The results demonstrated that 34% of respondents would recommend the service to others, with 52% reporting they were satisfied with the service. The quality of patient bedrooms scored low in the current survey. The previous family and friends test showed that 85% were satisfied with the service. The provider acknowledged that satisfaction rates in the most recent FFT survey was lower than previous years. The provider's governance meeting minutes demonstrated that the results from the survey were discussed regularly and staff planned to discuss the results with patients and parents. The provider recognised the service was lacking real time feedback and an electronic system would be required in order to capture the data. The provider had plans to purchase this equipment in 2016.
- Carers also had the opportunity of meeting with clinicians regularly to discuss their child and their experience of the service. Feedback was also received through the weekly community meeting from patients and the service provided a monthly support group for parents. A mindfulness programme was held at the service earlier in 2016, which aimed to support parents.
- Carers and relatives were positive about the service and stated that their relatives received good care at the hospital. Carers told us that they were informed of incidents on the ward when they attended MDT meetings and that the service responded well to any complaints or concerns raised. However, carers and relatives stated that patients would benefit from increased activities on the ward at evenings and weekends. Relatives and carers told us that their experience could be better when visiting the hospital by providing access to hot drinks. Some families had travelled a long distance and stayed at the hospital for long periods.
- The service thought of ways of involving families and carers in meetings by using teleconferencing. This promoted family involvement and provided opportunities for relatives to have direct input.
- There was good access for patients to advocacy services. Advocates regularly attended the ward community meetings and patients could also contact them independently when required. The advocacy service provided a monthly report and quarterly reports to the providers quality meetings which were reviewed in relation to developing themes.
- The provider did not involve patients and parents or carers in the recruitment of staff into the organisation.
- The service received, collated and shared with staff, regular post discharge thank you cards, letters and emails from previous patients and parents.

Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- The overall bed occupancy for Bryan Lask and Nunn ward for the six months prior to the inspection was 94%. The provider was a specialist service and accepted referrals from throughout the UK. The main referrers in the past 12 months were from the clinical commissioning groups in Norwich, Norfolk, Somerset, Gloucestershire and London. The provider did accept unplanned admissions in agreement with the

commissioners. Three emergency admissions had been made to the hospital from July to September 2015. A multi-agency review meeting took place prior to these admissions.

- The hospital provided a service to patients that had historically moved between psychiatric intensive care units (PICU) and eating disorder units. The clinical director stated that the service was created in order to meet the needs of patients with an eating disorder as well as patients that require intensive psychiatric treatment. Patients that were admitted to Bryan Lask ward were acutely unwell with high levels of dependency. Some complex patients with behaviours that challenged had been delayed in moving on to other placements.
- In the last six months, there had been two delayed discharges from the inpatient wards. One patient had been on the ward for two years and another other had been on the ward for 13 months. This was due to difficulties in locating an appropriate move on placement for the patient. In each case the provider had escalated the delayed discharge to the senior management team and liaised with other stakeholders in the patients care, to work in partnership to locate and secure a suitable move on placement. .

The facilities promote recovery, comfort, dignity and confidentiality

- Whilst the wards and cottage appeared clean, the décor and furnishings were tired and worn, and would benefit from updating.
- The service provided a range of therapy rooms and additional meeting rooms. The clinical rooms were equipped to support treatment and care. On Bryan Lask ward, there were separate treatment and clinical rooms. The treatment room was an identified room for where naso-gastric (NG) feeding took place. The room included an examination bed and equipment to check patients' blood pressure, pulse and weight. The clinical room on Nunn ward was used as a place to carry out NG feeds.
- One patient on Bryan Lask ward had been restrained and received nasogastric (NG) feeding in the main corridor on multiple occasions. This was because the patient could not be safely moved from their bedroom to the treatment room and posed a risk to themselves and others. Patients shared bedrooms, which did not afford sufficient space for patients to be safely supported when requiring physical interventions during NG feeds. The provider's analysis of incidents demonstrated that for one patient this happened frequently, sometimes several times each day. Staff aimed to promote patients privacy and dignity when physical interventions were used to support NG feeding in the corridor. Staff used a privacy curtain; however, this was only partially successful. In addition, other patients were able to hear incidents of physical intervention and NG feeding occurring, even when the privacy screen was successfully deployed. During our inspection, we observed physical interventions and NG feeding occurring by the entrance to Bryan Lask ward, with the incident visible on the ward and through the glass entry panel to the ward. Patients commented that they found seeing and hearing incidents of this kind distressing. For patients that did not attend school, the senior nurse told us that staff escorted other patients to the activity room when a physical intervention was planned. However, we did not observe staff escorting patients out of the ward on every occasion a planned physical intervention took place.
- On Nunn ward the patient information board could be seen through the glass panel on the office door, which meant that patients confidential information was not always protected.
- The ward environment was cramped and the corridors were narrow, which gave a sense of the wards being overcrowded. There was a lack of ventilation on the wards and there was little fresh air. The provider had provided air conditioning units for the wards following requests from the community meeting.
- Patients told us there was not enough seating for everyone. Nunn ward did not provide a quiet room for patients. The quiet room on Bryan Lask ward could not accommodate more than two people and only provided a two-seated sofa. The ward had used the room as a relative's room.
- Patients had access to individual mobile phones that they were provided with by the ward. The mobile phones did not have access to the internet, camera or video function as this was not allowed on the wards.
- The patients had access to a large garden, which provided a quiet and scenic space. Patients on the wards had set times in order to use the garden and ward staff supervised patients.

- The hospital had an on-site chef and a large kitchen where fresh meals were prepared daily. The food was of good quality and patients were provided with options according to advice from the dietician and meal plan. The dieticians tried to ensure that patient needs were taken on board including dietary requirements. We observed that the dining room on Nunn ward was small and crowded. All patients on the ward were expected to attend mealtimes together. Staff acknowledged that the dining room was small and told us that that the ward may use the cottage as another option for patients that were further advanced in their recovery at mealtimes.
- Some of the patients had personalised their bedrooms. However, the size of the bedrooms made it difficult for patients to decorate their room. The patients did not have a secure space to store their possessions.
- The activity timetable was visible on the notice boards on both wards. There was a comprehensive programme, which provided patients with a variety of activities during the week and the weekends. The ward provided games and reading books. Patients had individualised education timetables and patients were able to sit public exams such as GCSEs and A-level exams on site at the school.
- The service provided patients with access to a local child and young person's advocacy services who would attend the wards regularly to speak with patients if required. Notices were visible on the ward corridor, which provided contact information.
- Patients had access to two multi-faith rooms. The rooms included reading materials relating to a variety of faiths.

Meeting the needs of all people who use the service

- In the main reception area of the hospital there was a staff photo board, which provided all staff members name and their job role. This enabled relatives, carers and patients to be aware of the staff that worked at the hospital.
- The provider had made adjustments for people that required disabled access. Patients had access to a disabled toilet and bathroom on Bryan Lask ward. The provider accommodated patients with reduced mobility in a bedroom with en-suite facilities. However, Nunn ward did not provide patients with access to a disabled bathroom or bedroom. This was due to associated safety risks for patients, for example, fixed ligature points. Patients with reduced mobility were admitted to Bryan Lask ward, which provided the appropriate facilities, and patients were monitored and supervised closely.
- There was a variety of leaflets in the main reception area of the hospital, however not all of these were written for young people. Information included feedback forms, complaints information, Mental Health Act (MHA) rights and rights for informal patients. The leaflets were not provided in any other language apart from English. However, the provider assessed language needs during the referral process and information in a variety of languages could be obtained. Easy read versions were not available and staff did not know how these would be accessed.

Listening to and learning from concerns and complaints

- Patients and relatives knew how to make a complaint and could be supported by an advocated if they wished. The provider had a complaints policy and procedure and complaints were being appropriately investigated, however the outcome of complaint investigations was not always fed-back to patients or their families.
- The complaints policy outlined that comments were welcomed verbally, in writing or via the comments box, which was located in the reception area, however, there was no comments box in the reception and staff told us that feedback forms had always been handed to staff, which did not correspond with the providers' policy. Different records in use did not all correspond with the providers policy and procedure. For example, a log used to record feedback stated that complaints investigations would be completed within 28 days, which differed from the providers policy and procedure. Complaint investigation records were not routinely attached to complaints.
- There had been 25 formal complaints raised against the provider in the past 12 months. Three complaints were upheld and no complaints had been referred to the ombudsman. The theme of complaints included staff attitude, insufficient staffing, staff not being attentive, offensive remarks and injury during restraint. We reviewed 13 complaints and found that in nine instances, the provider had not met its own target of acknowledging complaints within 7 days. For two complaints, no acknowledgement had been sent at all. The delayed acknowledgement letters did not express

an apology and did not provide an explanation. Overall, the complaints system was not working well as records showed that 88% of the complaints had not met the targets that were set out in the provider's policy and procedure.

- Of the thirteen complaints we sampled, over 50% of complainants had not received a response to their complaint. Two additional complaints made verbally had been responded to. Whilst the provider had investigated complaints, these investigation records were not systematically stored and could not be readily located.
- Staff told us that feedback from investigations were discussed in nursing operation meetings (NOMs) and with the staff on the ward. The outcome of investigations was also discussed at the quality governance meeting. Minutes from these meetings showed that these discussions took place and were recorded. The provider had issued staff with lessons learnt leaflets that were attached to payslips. Three complaints had been received in September 2015, these had not yet been discussed at nursing operations meetings.

Are specialist eating disorder services well-led?

Requires improvement

Vision and values

- Staff were able to tell us that they wanted to help patients progress and recover, which corresponded with the providers aim. At the time of the inspection, the provider did not have a formal vision statement.
- All staff were aware of who the senior managers were within the hospital. Staff told us that the senior managers were approachable and involved in ward activity.

Good governance

- The provider had a range of governance systems in place; however, the providers' records showed that some were not operating effectively, for example: there was poor take up of mandatory training and training records were not up to date. Whilst staff were appraised and received regular group supervision, the majority of staff did not receive regular one to one clinical supervision.
- Over 50% of complainants did not receive a response to the concerns that they raised. Whilst the provider had safeguarding systems and procedures in place, take up of mandatory safeguarding training was low.
- The provider ensured that the majority of incidents were reported and investigated appropriately. However, we reviewed one incident where there had been no further investigation into the allegation. Senior managers reviewed incidents in the daily nursing meetings and the monthly quality governance meetings. The provider had identified from reviews of incident reports a theme of children and young people breaking free from supportive holds. As a result, the provider had arranged additional training for physical interventions. Permanent staff on Lask ward had completed the training programme.
- The provider had systems and procedures in place for infection control. However, the procedures were not robust and effective. An infection control audit had been carried out but this was not comprehensive and action points from the audit had not been reviewed and acted upon.
- Wards had introduced a safer staffing model, but this was not embedded into practice. The provider did not have robust systems for monitoring staffing levels and ensuring that skill mix, gender, training and annual leave was taken into consideration when planning the staffing rotas. The provider could not always ensure that sufficient numbers of staff who were familiar with patients' needs were on duty.
- The provider had met the commissioning for quality and innovation payment framework (CQUIN) targets in the past 12 months. The targets were set by the service commissioners in order to reward excellence with payments. The provider had several CQUIN targets, which included; improving physical healthcare to reduce premature mortality in people with severe mental illness and an eating disorder outcome measure for child and adolescents in inpatient settings. The CQUIN targets and performance indicators were reviewed within the provider's governance meetings and directly supervised by the senior management team. The commissioners had told us that since July 2015 that

the providers performance overall had increased. However, the quality governance meetings demonstrated that there had been no discussion of performance and CQUIN targets.

- The provider had acknowledged that the internal benchmarking system and monitoring of quality was in progress. The provider had employed a senior manager to focus on improving governance and assuring quality improvement. The provider reported quarterly to NHS England and the provider received regular feedback from them. The provider had set performance indicators which included; complaints, safeguarding, supervision and feedback from patients. The provider has also participated in a quality visit from the quality network of inpatient child and adolescent mental health services (QNIC).
- The wards had sufficient administrative support and the ward managers felt that they were well supported and had involvement in the clinical decisions made for the ward.
- The provider had an overarching risk register which senior managers were able to submit items. The risk register accurately reflected the potential risks identified during the inspection. The provider reviewed the risk register in monthly quality governance meetings. Staff raised any concerns with the ward manager who was able to escalate these issues. The risk register included the environmental risks and ligature points in the hospital and the garden. The provider had recently added the issue of the hospital not being equipped with an integrated alarm system to the risk register. Other items included risks relating to the use of physical interventions relating to nasogastric (NG) feeding. The risk register stated that staff had refresher training in the past 12 months for NG feeding. However, training records did not demonstrate this had happened.
- There was an internal quality assurance framework in place for 2015 to 2016, which identified 10 priorities. The provider recognised that there needed to be systems in place to allow the hospital to operate effectively. Priorities that had been completed at the time of the inspection included employing a senior member of staff to manage quality assurance and establishing an MDT group to review performance indicators (incidents, staffing and complaints).
- The provider did not involve patients and parents or carers in the recruitment of staff into the organisation.

Leadership, morale and staff engagement

- Staff survey results were mostly positive. The provider scored 74% for overall staff satisfaction in their jobs. Sixty-five percent of staff indicated that they felt equipped to do their jobs and 77% of staff felt they had the relevant training. The survey scores had been discussed in the provider's quality governance meeting.
- Sickness and absence rates were monitored by the provider overall. Overall staff sickness in the past 12 months had been 12% and the staff turnover rate had been 13%. The increased staff sickness had been due to a number of staff taking short periods of sick leave.
- Staff morale was good and staff felt supported by their manager and the wider MDT in their roles. The staff team was cohesive and worked well together, all staff felt able share their opinion. Staff acknowledged that at times their job had been challenging and tiring. However, staff shared the same aims and ultimately wanted to help patients get better.
- The provider had an educational fund, which was used for staff to develop within their roles and undertake specialist-training courses. During the inspection, we did not meet staff who had used the fund.
- Most staff we spoke with felt comfortable in raising concerns and the procedure for whistleblowing. There had been no whistleblowing's in the past 12 months.
- Some staff we spoke with were aware of the term duty of candour and others were less sure. Staff were aware of being open and transparent with patients and their carers or families.

Commitment to quality improvement and innovation

- The provider had a visit from the Quality Network for Inpatient CAMHS (QNIC) in the past 12 months. The quality review looked at the providers' standards for care and treatment as well as staff and training. QNIC gave the provider feedback about their strengths and suggestions for further improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are robust systems and processes in place in order to ensure that medical equipment, emergency equipment and fridge temperatures are checked regularly, clean and fit for purpose. Emergency equipment should be located in a place, which is accessible at all times.
- The provider must ensure that patients' privacy and dignity is promoted all times. For example, patients privacy and dignity during physical interventions that take place in communal areas of the ward during NG feeding, when patients share bedrooms and the display of patient information in nursing offices.
- The provider must ensure that all staff including, agency or bank staff, receive appropriate mandatory training which is relevant to the patient group and their role.
- The provider must ensure that its governance systems effectively monitor the delivery and quality of the service provided.
- The provider must ensure that there is an effective system to identify, receive, record, handle and respond to complaints by service users and other persons.

Action the provider SHOULD take to improve

- The provider should ensure that medicines are prescribed and managed in accordance with the provider's medicines management policy. This includes clearly documenting off-label medicines in care records.
- The provider should ensure that all clinical staff including agency staff receive appropriate specialist training which is relevant to the patient group.
- The provider should ensure that in addition to group supervision, staff receive regular, one to one supervision.
- The provider should ensure that the environment in which care is provided meets patients needs and that patients have a secure space to store their possessions. The provider should ensure that Bryan Lask ward is able to provide a female only lounge when male patients are admitted to the ward.
- The provider should ensure that ensure that all staff, including bank and agency are polite and approachable and engage with patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patient's privacy and dignity was not always being protected. The provider had not ensured this was upheld during physical interventions and did not ensure that patient records were stored in a place where they could not be seen by others. This was in breach of regulation 10 (1)(2)(b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The system in place to check clinical equipment and emergency equipment was not robust as the defibrillator pads and oxygen masks had expired. The emergency equipment was located in one place only. Infection control procedures and protocols were not robust enough. Fridge temperatures were not routinely checked which could have an impact on patient safety. Mandatory training rates were low and the provider could not be sure that staff were equipped to carry out their role safely. This was in breach of regulation 12(1)(2)(b)(d)(e)(g)(h).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The provider had not ensured that there were effective systems and processes in place to ensure the service was assessed and monitored.

This was in breach of regulation

17(1)(2)(f).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had not ensured that there was an effective accessible system in place for identifying, receiving, recording, handling and responding to complaints by service users and other persons. This was in breach of regulation 16(2).