St Andrew's Healthcare - Womens service

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

Overall summary

We did not rate this service.

We carried out this inspection in response to concerning information received through our monitoring processes.

We found the following areas the provider needs to improve:

- Managers did not ensure staff had the right skills, knowledge and experience to meet the needs of patients with a diagnosed eating disorder. Staff had not completed full assessments for patients with a diagnosed eating disorder prior to admission. Staff had not completed care plans that met all the needs of patients with a diagnosed eating disorder. Staff did not provide a range of care and treatment options suitable for this patient group.
- Staff did not manage patient risks effectively. Staff did not always complete observations in line with patient care plans and the provider's policy and procedures. Staff did not complete care plans for all identified risks. Staff had not met all patients' physical health needs.
- Managers did not provide a safe environment for patients. The ward was not resourced with equipment required to support patients with an eating disorder. A patient was in a distressed state for over an hour due to lack of specialist equipment. Staff did not follow correct infection control procedures in relation to coronavirus. We observed staff not wearing personal protective equipment (face masks) appropriately when on the ward.
- Staff did not always treat patients with kindness, dignity and respect. We observed a senior member of staff dismiss a patient who asked to speak with them about safeguarding concerns. We spoke with a senior member of staff who described patients with an eating disorder as "not a patient group who inspires excitement". Patients described occasions when they were distressed and staff ignored them.
- Staff did not always identify and report safeguarding concerns. Managers had not notified CQC about seven out of eight safeguarding incidents and had not referred one to the local authority safeguarding team.
- Carers reported issues with communication and gave examples of having to 'battle' to be listened to and be involved. Patients and carers reported that managers were dismissive of concerns raised.
- Patients told us that there was not enough food, catering staff did not send meals or sent the wrong meals, food was sometimes "mouldy" and was not always cooked properly. Patients told us there were limited food options, especially if vegetarian. This was

Summary of findings

raised on numerous occasions in community meetings with no evidence of any action taken. However, we reviewed evidence that staff checked quality and temperature before serving food.

- Managers had not effectively managed the change to the ward profile. Managers continued with the planned change despite training not being available, due to coronavirus restrictions, and the ward not being sufficiently resourced. Managers had not followed recommendations from an internal investigation into concerns raised.

However:

- Senior leaders demonstrated learning by acknowledging that a lesson learnt was to ensure new services have the correct capabilities in place prior to opening and reported that they were making changes following concerns being raised.
- Staff completed annual physical health assessments for all patients and completed standard physical health checks. We saw evidence in progress notes that staff sought support from the provider's physical health team when required.
- Staff supported one patient sensitively on the anniversary of a traumatic life event.
- Patients described the new dietician as 'amazing'.
- Two carers told us that the social worker was helpful and another two told us their relative was in the right place for the care and treatment they needed.

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Background to St Andrew's Healthcare - Womens service

St Andrew's Healthcare Women's service registered with the CQC on 11 April 2011. The Women's service is situated on St Andrew's Healthcare Northampton site. The other registered locations at Northampton are Children and Adolescents Mental Health services, Men's services, Women's services and Neuropsychiatry services.

St Andrew's Healthcare also have services in Birmingham, Nottinghamshire and Essex.

St Andrew's Healthcare Women's service consists of four core services.

St Andrew's Healthcare Women's service has been inspected seven times.

St Andrew's Healthcare Women's service is registered to provide the following regulated activities:

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

The service has a nominated individual and a registered manager.

We inspected women's services to follow up on concerning information received through our monitoring processes.

The following services were visited on this inspection:

Long stay / rehabilitation wards for working age adults/ Specialist eating disorders services:

We inspected the following ward at the women's location:

• Spencer South ward is a 12 bedded ward. There were 11 patients on the ward when we visited. The ward is described by the provider as an "inpatient care and rehabilitation service providing highly specialist care for women with emotionally unstable personality disorders and associated complex eating disorder needs." The ward was previously a low secure long stay/ rehabilitation ward and changed to provide this service on 01 April 2020.

This service was last inspected in March 2020 during a comprehensive inspection of the Women's location that was brought forward following concerns received through our monitoring processes. The Women's location was rated inadequate and placed in special measures.

Following the last comprehensive inspection enforcement action was taken for breaches of the following regulations:

- Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Dignity and respect.
- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safe care and treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Good governance.

Requirement notices were issued for breaches of the following regulations:

- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.
- Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Staffing.

Our inspection team

The team that inspected the service comprised one inspection manager and three CQC inspectors.

Summary of this inspection

Why we carried out this inspection

We undertook this inspection to follow up on concerning information received through our monitoring of St Andrew's Healthcare women's services.

How we carried out this inspection

We conducted this inspection on site and remotely to minimise risks in relation to coronavirus.

We have reported in all of the five key questions; safe, effective, caring, responsive and well led. As this was a focused inspection, we looked at specific key lines of enquiry in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

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

During the inspection visit, the inspection team:

- visited Spencer South ward and looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with eight patients who were using the service;
- spoke with seven carers/relatives;
- interviewed the nurse manager for the ward;
- interviewed two senior managers;
- spoke with four other staff members; including nurses, healthcare assistants and the consultant psychiatrist.
- looked at ten care and treatment records of patients;
- reviewed nine incident records;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We spoke with eight patients. All patients reported negative experiences of their care and treatment on the ward.
- The patients with a diagnosed eating disorder told us that they did not feel safe and they had no confidence in the staff's capability to support them to manage their eating disorder needs. These patients also told us that they supported each other and accessed external helplines and websites for support. Two of the patients told us that the ward did not have the required specialist equipment, for example, pressure relieving mattresses that they required and they subsequently developed pressure sores.
- Patients described occasions when they were distressed and staff ignored them.
- Three patients disclosed incidents of verbally abusive and inappropriate behaviour by two staff (which CQC inspectors referred to the local authority safeguarding team).
- Prior to the change to have two mealtime sittings (instigated following an incident described by patients as a 'food fight'), patients with eating disorders reported being forced to eat with patients without eating disorders and that this caused distress and anxiety.
- Patients told us that there was not enough food, catering staff did not send meals or sent the wrong meals, food was sometimes "mouldy" and was not always cooked properly.
- Patients described a punitive approach by staff, for example, staff threatening to strip a patient's bedroom of their belongings if they did not get up on time.
- Patients also told us that the showers were cold, sometimes flooded and that there had been infestations of ants on the ward.
- Patients told us there was a lack of staff support during mealtimes and there was often only one staff member in the day area when there should be three.
- Patients told us that staff were not wearing personal protective equipment correctly in relation to coronavirus infection control procedures.

Summary of this inspection

- However, patients described the new dietician as ‘amazing’ and described some staff as being helpful and kind.

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?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Managers did not provide a safe environment for patients. The ward was not resourced with equipment required to support patients with an eating disorder. For example, pressure relieving equipment, specialist lifting equipment and appropriate scales. A patient was in a distressed state for over an hour due to lack of specialist equipment.
- Staff did not follow infection control procedures in relation to coronavirus. We observed staff not wearing personal protective equipment (face masks) appropriately when on the ward. Staff were wearing masks under their chin or they were not covering their nose.
- Staff did not manage patient risks. Staff did not always complete observations in line with patient care plans and the provider's policy and procedures. Staff did not complete care plans for all identified risks, for example over exercising, self induced vomiting and laxative abuse.
- Staff did not always identify and report safeguarding concerns. Patients reported incidents of staff inappropriate behaviour and verbal abuse and of bullying by other patients. Patients advised that they raised these concerns with ward staff, but no action had been taken. CQC and other external agencies referred these concerns to the local authority safeguarding team.
- We reviewed eight safeguarding incidents reported between 01 April 2020 and 30 June 2020, managers had not notified CQC about seven of the incidents and had not referred one to the local authority safeguarding team.

However:

- The provider reported a mandatory training compliance for staff on Spencer South ward of 85% as of 01 July 2020.

Are services effective?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Staff had not completed full assessments for patients with a diagnosed eating disorder prior to admission. Staff had not completed care plans that met all the needs of patients with a

diagnosed eating disorder. Staff identified risk behaviours associated with the patient's eating disorder for four patients but only one patient had care plans in place to manage these risks.

- Staff did not provide a range of care and treatment options suitable for the patient group. The service offered Dialectical Behaviour Therapy. Whilst, the National Institute of Healthcare Excellence guidance states "there is little evidence on which treatments work best for people with an eating disorder and a comorbidity", they also state that "preferences of the person with the eating disorder and (if appropriate) those of their family members or carers" should be taken into account. Patients told us they were accessing external websites and helplines for support. Staff had not provided individual therapeutic timetables in line with ward procedures.
- Staff had not met all patients' physical health needs. Staff were not always weighing patients with an eating disorder in line with their care plans. The dietician increased one patient's calorific intake following weight loss. The patient continued to lose weight and staff had not kept clear records of the patient's calorific intake.
- Managers had not ensured staff had the right skills, knowledge and experience to meet the needs of patients with a diagnosed eating disorder. There had been no formal eating disorder training provided to staff. Managers facilitated ward based teaching sessions from June 2020. Only four staff attended all sessions and six staff attended none. Staff had not completed training to use specialist lifting equipment required by one patient.
- Managers advised that specific policies and procedures for the ward were included in the standard operating procedure. The standard operating procedure was dated January 2020 and had not been updated following the change to the ward profile on 01 April 2020.

However:

- Staff completed annual physical health assessments for all patients and completed standard physical health checks. We saw evidence in progress notes that staff sought support from the provider's physical health team when required.

Are services caring?

We did not rate this key question.

We found the following areas the provider needs to improve:

Summary of this inspection

- Staff did not always treat patients with kindness, dignity and respect. Staff demonstrated a lack of enthusiasm for the patient group they were supporting. We observed a senior member of staff dismiss a patient who asked to speak with them about safeguarding concerns. We spoke with a senior member of staff who described patients with an eating disorder as “not a patient group who inspires excitement”. Patients described occasions when they were distressed and staff ignored them.
- Patients reported that staff “had a go” at them for making complaints. We found examples of inappropriate language being used by staff in patient records, for example reference to patients “bragging about talking to CQC”, “x and some of her peers have engaged in unhelpful conversations regarding CQC and the complaints they have made about staff”.
- Patients facilitated and attended weekly community meetings. Staff did not respond to all concerns raised in these meetings including numerous complaints made about the quality and quantity of food.
- Carers reported issues with communication and gave examples of having to battle to be listened to and be involved. Two carers advised that they thought the quality of care and treatment on the ward deteriorated since they complained. Two carers did not think the ward was prepared and equipped to support their relative.

However:

- Staff supported one patient sensitively on the anniversary of a traumatic life event.
- Two carers told us that the social worker was helpful. Two carers told us their relative was in the right place for the care and treatment they needed.

Are services responsive?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Facilities did not always promote dignity and confidentiality. Staff used the quiet room to administer nasogastric feeds. This room was not sound proofed and therefore other patients could hear if a patient was distressed. The CQC reported this as a concern during the comprehensive inspection in March 2020.
- Patients told us that there was not enough food, catering staff did not send meals or sent the wrong meals, food was sometimes "mouldy" and was not always cooked properly. Patients told us there were limited food options, especially if

vegetarian. This was raised on numerous occasions in community meetings with no evidence of any action taken. However, we reviewed evidence that staff checked quality and temperature before serving food.
- Patients and carers reported that managers had been dismissive of their complaints. The inspection team found that a senior leader was also dismissive of the complaints.

Are services well-led?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Managers had not effectively managed the change to the ward profile. Managers continued with the planned change despite training not being available and the ward not being sufficiently resourced. Managers had not followed recommendations from an internal investigation into concerns raised.
- Frontline staff spoken with reported that morale was low and that they did not feel equipped to support patients with an eating disorder effectively.
- Managers reported internal and external pressures to admit new patients to the ward. This resulted in staff admitting patients without a full assessment and this placed pressure on ward based staff.

However:

- Senior leaders demonstrated learning by acknowledging that a lesson learnt was to ensure new services have the correct capabilities in place prior to opening and reported that they were making changes following concerns being raised.

Long stay or rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long stay or rehabilitation mental health wards for working-age adults safe?

Safe and clean environment

The environment was not safe or clean. The ward was cluttered in places, for example, the therapy room and clinical examination room. Patients and relatives told us about and shared a photograph of, a stool in a serious state of disrepair.

The ward did not have the equipment required to support patients with an eating disorder. For example, pressure relieving equipment, specialist lifting equipment or specialist scales. The ward manager advised that no current patients required pressure relieving equipment. However, we reviewed records for a patient admitted a week before the inspection, who ward staff assessed as requiring a pressure relieving mattress, suitable weighing scales and specialist lifting equipment. Staff scored the patient as 'at risk' following a Waterlow assessment completed on 01 July 2020. A Waterlow assessment is a scoring system that looks at seven risk factors that contribute to the development of pressure ulcers. The ward manager updated CQC following the inspection to advise the patient no longer required a pressure relieving mattress and that the ward purchased suitable scales, we viewed a delivery note dated 20 July 2020 that confirmed this.

Staff did not follow infection control procedures in relation to coronavirus. We observed staff not wearing personal protective equipment (face masks) appropriately when on the ward. Staff were wearing masks under their chin or they were not covering their nose. We escalated this to senior managers who advised this had been identified as an issue across the provider's locations and the chief executive sent an email to all staff reminding them of the importance of following infection control procedures.

Patients told us staff had not provided any information, updates or education about coronavirus and they found out themselves from the news and family. We checked this by looking at 21 weekly community meeting minutes from February 2020, which only mentioned coronavirus restrictions on 30 March 2020 and 06 April 2020.

Safe staffing

We reviewed staffing data from 01 April 2020 to 30 June 2020. There were no unfilled shifts reported and senior leaders advised that all shifts were above the required numbers with 72% of shifts filled by permanent staff.

We reviewed shift planners for the 04 June 2020 and the 17-28 June 2020. We requested shift planners for May 2020 but were advised that these were no longer available. Shift planners indicated that staffing was below the required numbers on all 13 days reviewed. We queried this with the senior leaders who advised that the staffing data covered 24 hours whereas the shift planners only included day shifts.

We were told one staff should be present in the lounge area at all times and three staff were required for meal time support. All patients spoken with told us that there were not always enough staff in the dining room at meal times. Managers confirmed that they identified this as an issue and put forward a case for increased staffing to support meal times.

We observed the lounge area during the site visit on two separate occasions. On both occasions there was only one staff member present. On one occasion there were four

patients and one staff member present initially, a second staff member joined later. Patients were expressing their unhappiness about being on the ward and staff said it was hard as the ward was often understaffed.

During the site visit on the 8 July 2020 the following staff were on shift; three qualified (two permanent and one agency), four healthcare assistants (all permanent). There were 11 patients on the ward, five with an eating disorder diagnosis. Staff prescribed 15 minute observations for one patient and an hour of post meal observations for three patients. This was sufficient staff to carry out all required aspects of care and support.

The provider reported a mandatory training compliance for staff on Spencer South ward of 85% as of 01 July 2020.

Assessing and managing risk to patients and staff

Staff did not always complete observations in line with the provider's policy and procedures.

We reviewed 205 pages of observations records from 01 July 2020 to 16 July 2020 for a patient prescribed a combination of five and 15 minute intermittent observations. Staff did not complete all observation records correctly. Staff had not detailed the patient's name or initials on 14 pages and we found two examples of the wrong initials recorded; we found 35 incomplete entries (for example, no location, no risk behaviours and no staff details); staff had not detailed the risk and rationale for observations on nine out of 31 pages; we found no date on 21 pages and three occasions when staff had not changed the date at midnight; we found no page numbers on 81 out of 92 pages; staff had not recorded the consultants name on 12 out of 31 pages. We were concerned that the 15 minute observations were being completed on the quarter hour interval each time, ie 09:00, 9:15, 09:30, 09:45, this was not in line with the provider's policy which states "learning points from investigations have identified that checks made at the specified time e.g. every 15 min, may increase the risks that patients anticipate a period of being routinely unobserved. Therefore, ad hoc checks within the specified period are preferable to checks following the same time interval."

Staff identified three patients at risk of purging their food and prescribed post meal observations for an hour. One patient told us staff often allowed her to use the toilet unobserved in this time. We requested observation records for the prescribed post meal observations, managers advised staff did not keep observation records and details would be in individual patient progress notes. We reviewed progress notes for all three patients and found two brief references to post meal supervision. We reviewed shift planners for June 2020, shift leads had not allocated staff to the task of observing patients after meal times, therefore there was no evidence that this support was being provided as prescribed. We reviewed an incident when staff allowed one of the patients prescribed post meal observations to go to her bedroom unsupervised immediately after her evening meal. The patient's bathroom was unlocked, when it should have been locked in line with the patient's care plan due to risks of purging. The patient had to ask staff to lock the bathroom.

We observed exercise equipment located on the ward, we were concerned that patients with an eating disorder had unsupervised access. One patient spoken with confirmed that they were able to access the equipment with no limitations on time, another told us they had seen patients with an eating disorder using the equipment unsupervised. The manager advised the equipment was upstairs and locked off during the day, however patients told us they had unsupervised access to the upstairs area in the evening. Two patients told us that they were encouraged to take 'power walks' to burn off calories. The ward timetable included walking as an activity. We only found one patient record where staff completed a care plan to manage the risks associated with underweight patients exercising.

We spoke with two patients who described how physically frail they were when admitted and that staff told them they had to use the stairs, rather than the lift, which they found difficult.

We reviewed an incident where a patient was in a distressed and upset state for over an hour as staff did not have quick access to the necessary equipment or staff trained to use it appropriately. Staff had assessed the patient as requiring this equipment, however referring clinicians advised staff the patient did not require this equipment. Staff reported that they had been requesting specialist input to help support this patient for over a week.

Safeguarding

Staff did not always identify and report safeguarding concerns. Patients reported incidents of staff inappropriate behaviour and verbal abuse and of bullying by other

patients. Patients advised that they raised these concerns with ward staff, but no action had been taken. CQC and other external agencies referred these concerns to the local authority safeguarding team.

We reviewed all safeguarding incidents (eight) reported between the 01 April 2020 and 30 June 2020. Staff had not classed an incident where a patient was left in a distressed state for over an hour due to the ward lacking the correct equipment as a safeguarding. It was the inspection teams view that this incident should have been referred to the local authority safeguarding team as an act of omission/ neglect.

Reporting incidents and learning from when things go wrong

We reviewed eight safeguarding incidents reported between 01 April 2020 and 30 June 2020, managers had not notified CQC about seven of these incidents. The Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service, or the people using it, are notified to CQC.

The ward made changes following incidents. One example was the ward changing to two meal time sittings (one for patients with an eating disorder and one for patients without) following an incident where patients had thrown food, drinks and plates.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Assessment of needs and planning of care

MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) is guidance developed by the Royal College of Psychiatrists following concerns about worrying variations in practice when treating patients with anorexia nervosa. The ward operating procedure (dated January 2020) stated that "we are able to accept patients with a BMI of 13 and above, but the patient must be physically stable (as measured by the MARZIPAN (sic) checklist). The operating procedure further states in the exclusion criteria that a patient will not be admitted if "physically (sic) health unstable as a result of disordered eating (as measured by the MARZIPAN (sic) checklist).

However, we were advised by senior leaders in July 2020 that only very recently had the admissions procedure been amended to include the MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) checklist. Staff completed this for the most recent admission in July 2020, but had not completed it for admissions between January 2020 and June 2020.

Staff completed care plans for all patients, however for those patients with a diagnosed eating disorder the plans were lacking in detail to effectively support this aspect of their care. Senior staff acknowledged that care plans for patients with an eating disorder lacked the required detail and reported that they fed this back to senior leaders for the ward and advised ward staff to follow the Royal College of Psychiatry 'Adult Eating Disorders' guidance to ensure sufficient detail was included.

The ward operating procedure stated that "any additional behaviours (e.g. bingeing, over-exercising) linked to unhealthy beliefs around body shape and food will be individually care planned and described in patient's Positive Behaviour Support (PBS) Care Plan". We reviewed the PBS plans for all five patients with a diagnosed eating disorder. Staff identified risk behaviours associated with the patient's eating disorder for four of the patients but only one patient had care plans in place to manage these risks. These risks included restricting food intake, over exercising, self induced vomiting and laxative abuse.

Staff completed a nutritional screening assessment for all patients with a diagnosed eating disorder. However, these plans followed a set text and were not personalised to each patient.

Best practice in treatment and care

Staff did not provide a range of care and treatment options suitable for the patient group. Patients with a diagnosed eating disorder told us they received no support for their eating disorder. Staff spoken with told us they were unaware of how to support patients with an eating disorder.

The service offered Dialectical Behaviour Therapy. The National Institute of Healthcare Excellence guidance states

"there is little evidence on which treatments work best for people with an eating disorder and a comorbidity. A modified eating disorder therapy that addresses both conditions may avoid the need for different types of therapy (either in parallel or one after the other). Alternatively, a comorbidity may be severe enough that it needs addressing before treating the eating disorder, or treatment solely for the eating disorder may help with the comorbidity." However, the National Institute of Healthcare Excellence also states that "when deciding which order to treat an eating disorder and a comorbid mental health condition (in parallel, as part of the same treatment plan or one after the other), take the following into account: the severity and complexity of the eating disorder and comorbidity; the person's level of functioning and preferences of the person with the eating disorder and (if appropriate) those of their family members or carers."

Patients told us there was no body image therapy offered and that they were accessing external websites and helplines for the support they needed.

The ward operating procedure stated “individual therapeutic timetables are based on the needs identified in PBS (Positive Behavioural Support) care plans.” We requested copies of each patient’s timetable and were told that patients work off the ward timetable so individual time tables were not required.

Staff were not always weighing patients with an eating disorder in line with their care plans. We reviewed records for two patients who staff care planned to be weighed weekly. Staff had not weighed one patient for four weeks and the other for almost two months. Staff had not documented any refusals during these times.

The dietician increased one patient’s calorific intake following weight loss of 5.3kg over six months. However, the patient continued to lose weight and staff had not kept clear records of the patient’s calorific intake. Patients spoken with complained about a lack of food and meals not having sufficient calories.

However, staff completed annual physical health assessments for all patients and completed standard physical health checks. We saw evidence in progress notes that staff sought support from the provider’s physical health team when required.

Staff did not complete all reported outcome measures for patients. We reviewed outcome dashboards for six patients, three diagnosed with Emotionally Unstable Personality Disorder and an eating disorder and three diagnosed with Emotionally Unstable Personality Disorder. Staff completed Health of the Nation Outcome scales for three patients; four patients completed Recovering Quality of Life; staff completed the Clinical Global Impression scale for all six patients. We found no evidence that staff or patients completed further outcome measures despite managers reporting use of the following outcome measures: Behavioural data- Self-injurious behaviours, violence towards others (verbal and physical), violence towards property; Clinical Outcomes in Routine Evaluation; Recovering Quality of Life; Eating Disorder Examination Questionnaire; Health of the Nation Outcome Scale – Secure version and Clinical Global Impression scale – Symptoms and Severity. The provider later advised that this information was contained within the patients' electronic records but was not easily accessible to either CQC or the provider’s senior staff. If information is not readily available, then its subsequent use is diluted. Information should be easy to locate for all staff who need access, including senior staff.

Skilled staff to deliver care

The team included a dietician, an occupational therapist, a psychologist, a social worker, consultant psychiatrist, nurses and healthcare assistants. The dietician had experience of working with patients with an eating disorder and was spoken highly of by patients, however until recently they worked across three wards. Senior leaders recognised that the ward required a full time dietician and recently changed the dietician’s role to be based at Spencer South only.

Managers reported a vacancy for an occupational therapy assistant and a speciality doctor.

The consultant psychiatrist was spread across two wards with plans to be full time for Spencer South ward once a consultant was recruited to the other ward.

There were insufficient staff with the right skills, knowledge and experience to meet the needs of patients with a diagnosed eating disorder. There had been no formal eating disorder training provided to staff. Managers reported that they planned training at another hospital location but this was postponed due to the coronavirus outbreak. Managers acknowledged that training had been

primarily to meet the needs of Emotionally Unstable Personality Disorder and there were gaps in the skills and knowledge of the staff group in relation to supporting patients with an eating disorder.

The consultant psychiatrist and dietician started weekly teaching sessions from the 04 June 2020. Out of 26 staff, five (including the ward manager) completed Naso gastric feed training; 17 attended the 'Staff and patients dining room etiquette' session; 10 staff attended the Motivation and Psycho-educational Package for People with Eating Disorders (MOPED) teaching session; nine staff attended the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) teaching session. Six staff had not attended any of the teaching sessions. Only four staff attended all three teaching sessions.

The ward operating procedure stated that "staff will be given training on portion sizes (half-portions, full portions and maintenance portions). Not all staff had completed portion control training, 13 out of 23 staff had completed this by 30 June 2020. One patient required staff trained in using specialist lifting equipment. Staff had not completed this training and managers advised this was planned for the end of July 2020.

Managers advised that specific policies and procedures for the ward were included in the standard operating procedure. The standard operating procedure was dated January 2020 and had not been updated following the change to the ward profile on 01 April 2020.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with kindness, dignity and respect. Staff demonstrated a lack of enthusiasm for the patient group they were supporting. We observed a senior member of staff dismiss a patient who asked to speak with them about safeguarding concerns. The patient left in a distressed state and no other staff went to check if they were ok. A member of the inspection team checked that the patient was ok. We spoke with a senior member of staff who described patients with an eating disorder as "not a patient group who inspires excitement". Other senior staff described patients as disturbing the ward, undermining staff and manipulating authority figures.

Prior to the change to have two mealtime sittings (instigated following an incident described by patients as a 'food fight'), patients with eating disorders reported staff forcing them to eat with patients without eating disorders and that this caused distress and anxiety. Patients described occasions when they were distressed and staff ignored them.

Patients reported that staff met with them after they raised concerns with CQC and "had a go" at them for making complaints.

We found examples of inappropriate language being used by staff in patient records, for example reference to patients "bragging about talking to CQC", "x and some of her peers have engaged in unhelpful conversations regarding CQC and the complaints they have made about staff" and notes from a ward round that stated "during the beginning of the review period x was involved in conversations with peers talking very negatively about the ward in reference to staff and care given". We also found the following reference to patients in an incident report; "individuals with pertinent eating behaviours".

We reviewed the records of one patient, who staff supported sensitively on the anniversary of a traumatic life event.

Involvement in care

Patients expressed that they felt choices had been taken away, for example, not being given a choice of treatment.

Patients facilitated and attended weekly community meetings. Staff did not respond to all concerns raised in these meetings. We reviewed minutes of 21 community meetings dating from 03 February 2020 to 21 July 2020. Patients made complaints about food being cold on nine occasions with no evidence that any action has been taken to address this issue. Additional complaints had been made regarding no meals or the wrong meals being sent and mouldy salad, there was no evidence of any action taken to address. On 01 June patients asked for more time to have e-cigarettes and this was refused.

We spoke with seven carers of patients on the ward. All carers reported issues with communication and some gave

examples of having to battle to be listened to and be involved. One carer expressed surprise that their views had not been sought in relation to their loved one's care and treatment when they were admitted. Two carers advised that they thought the quality of care and treatment on the ward deteriorated since they complained. Two carers reported that the dietician was good and put effective plans in place, but staff have not had the right training and support to follow the plans correctly. Two carers did not think the ward was prepared and equipped to support their relative. Two carers told us that the social worker was helpful. Two carers told us their relative was in the right place for the care and treatment they needed.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Access and discharge

The service had not managed access to the ward effectively following the change to the ward profile.The service admitted patients that fitted the new ward profile, before discharging patients that fitted the old profile. However, changes had recently been made to improve access arrangements and managers advised they were planning to discharge two patients before admitting one new patient to better manage the change.

Managers reported there were six patients on the waiting list for the ward; three patients waiting for a bed and three waiting for an assessment.

The facilities promote recovery, comfort, dignity and confidentiality

Facilities did not always promote dignity and confidentiality. Staff used the quiet room to administer nasogastric feeds. This room was not sound proofed and therefore other patients could hear if a patient was distressed. The CQC reported this as a concern during the comprehensive inspection in March 2020.

Meeting the needs of all people who use the service

Staff did not meet the needs of all people using the service. Patients told us that there was not enough food, catering staff did not send meals or sent the wrong meals, food was sometimes "mouldy" and was not always cooked properly. Patients told us there were limited food options, especially if vegetarian. This was raised on numerous occasions in community meetings with no evidence of any action taken. However, the service provided evidence following the inspection that patients' dietary choices were provided to the kitchen and a sample of four days in June and July when quality checks were completed. We also reviewed evidence that the temperature of food was checked and above required temperature before serving.

Listening to and learning from concerns and complaints

Staff did not always listen and learn from complaints. Patients and carers reported that managers had initially been dismissive of their complaints. The inspection team found that a senior leader was also dismissive of the complaints. However, carers reported that they recently met with representatives from the provider to discuss their concerns.

We reviewed complaints information from the provider. The provider logged six complaints from 01 April 2020 to 30 June 2020. One complaint was marked as 'completed' but did not include an outcome. Five of the six complaints had been made in June and were subject to ongoing investigation. The response due dates ranged from 03 July 2020 to 15 July 2020. Senior leaders advised that complaints responses would not be ready until mid-August. However, the provider advised they had decided, in agreement with the complainants, to group the complaints together as they were linked by common themes.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Leadership

Managers did not have a good understanding of the service they managed. Managers did not ensure the ward was resourced to meet the needs of the patient group and had not acted on concerns raised in the last inspection. Managers had not ensured that staff followed policies and procedures.

Long stay or rehabilitation mental health wards for working age adults

Managers of the service were in newly formed roles. The provider recently changed the leadership structure of services, introducing new divisions with a clinical director, head of nursing and head of operations overseeing. Prior to the inspection the ward manager was split between two wards and senior leaders recently changed this role to only cover Spencer South.

Culture

Staff did not feel respected, supported and valued. Frontline staff spoken with reported that morale was low and that they did not feel equipped to support patients with an eating disorder effectively. Staff were not positive about working for the service.

Governance

Leaders had not effectively managed the change to the ward profile. The ward profile changed on 01 April 2020 to support patients with a diagnosis of Emotionally Unstable Personality Disorder and an eating disorder. Leaders had drawn up plans to make this change gradually and provide specialist training to staff to ensure they were able to support patients safely and effectively. Due to the coronavirus pandemic staff training was not able to proceed as planned, however, leaders made the decision to continue with the change to the ward profile and admitted patients with an eating disorder.

Leaders reported internal and external pressures to admit new patients to the ward. This resulted in patients being admitted without a full assessment and this placed pressure on staff who were not equipped to support these patients.

Following the CQC feeding back concerns about the service to senior leaders, they advised that they were suspending admissions until the whole staff team completed Motivation and Psycho-educational Package for People with Eating Disorders (MOPED) and 'Staff and patients dining room etiquette' training. However, managers subsequently went on to admit a patient before all staff completed this training. We were told this was due to risks to the patient if they remained at their previous placement. Managers had not ensured the ward was equipped to meet the needs of this new patient.

Information management

Managers had not made notifications to external bodies as required. We reviewed eight safeguarding incidents reported between 01 April 2020 and 30 June 2020, managers had not notified CQC about seven of the incidents and not referred one to the local authority safeguarding team.

Learning, continuous improvement and innovation

Senior leaders demonstrated learning from concerns that had been raised about the service. They acknowledged that a lesson learnt was to ensure new services have the correct capabilities in place prior to opening.

Senior leaders made improvements to the service following concerns being raised. These included making key roles full time for the ward, changes to the admissions process and the introduction of teaching sessions to support staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure effective care and treatment is provided to patients that meets their needs and is in line with national guidance. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including use of appropriate language. (Regulation 10 (1))
- The provider must ensure that staff providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (1) (2) (c))
- The provider must ensure staff identify and manage all patient risks. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff undertaking patient observations do so in line with care plans and their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure staff meet the physical health needs of patients. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure the ward is resourced with the equipment required to meet patients' needs. (Regulation 12 (1) (2) (a) (b) (f))
- The provider must ensure staff report and record all safeguarding incidents appropriately, notifying external agencies when required. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff follow infection control procedures. (Regulation 12 (1) (2) (h))
- The provider must complete and send statutory notifications for all notifiable incidents as soon as possible after the incident. (Regulation 18 (Registration) Regulations (2) (e))

Action the provider SHOULD take to improve

- The provider should act on learning and recommendations to ensure any future changes to service provision are properly executed in line with plans.
- The provider should ensure patients receive good quality food in line with their meal plans and preferences.
- The provider should ensure service procedures are updated to reflect the service provision.
- The provider should ensure staff take action and record this in response to concerns raised in community meetings.
- The provider should ensure staff effectively communicate with all carers.

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 9 HSCA (RA) Regulations 2014 Person-centred care • Staff did not provide a range of care and treatment options suitable for the patient group. The only therapy offered was Dialectical Behaviour Therapy. Whilst, the National Institute of Healthcare Excellence guidance states "there is little evidence on which treatments work best for people with an eating disorder and a comorbidity", they also state that "preferences of the person with the eating disorder and (if appropriate) those of their family members or carers" should be taken into account. Patients told us they were accessing external websites and helplines for support. • The ward operating procedure stated "individual therapeutic timetables are based on the needs identified in PBS care plans." We requested copies of each patients timetable and managers advised that patients work off the ward timetable so individual time tables were not required. This was a breach of regulation 9

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 • Staff did not always treat patients with kindness, dignity and respect. We observed a senior member of staff dismiss a patient who asked to speak with them about safeguarding concerns. We spoke with a senior member

This section is primarily information for the provider

Requirement notices

of staff who described patients with an eating disorder as "not a patient group who inspires excitement". Patients described occasions when they were distressed and staff ignored them.

- Patients reported that staff "had a go" at them for making complaints. We found examples of inappropriate language being used by staff in patient records, for example reference to patients "bragging about talking to CQC", "x and some of her peers have engaged in unhelpful conversations regarding CQC and the complaints they have made about staff".

This was a breach of regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Staff did not always identify and report safeguarding concerns. Patients reported incidents of staff inappropriate behaviour and verbal abuse and of bullying by other patients. Patients advised that they raised these concerns with ward staff, but no action had been taken. CQC and other external agencies referred these concerns to the local authority safeguarding team. This was a breach of regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents • We reviewed eight safeguarding incidents reported between 01 April 2020 and 30 June 2020, managers had not notified CQC about seven of these incidents. This was a breach of regulation 18

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Managers had not ensured that staff providing care or treatment to patients had the qualifications, competence, skills and experience to do so safely. There had been no formal eating disorder training provided to staff. Managers facilitated ward based teaching sessions from June 2020. Only four staff attended all sessions and six staff attended none. Not all staff had not completed portion control training or training to use specialist lifting equipment required by one patient. • Staff had not met all patients' physical health needs. Staff were not always weighing patients with an eating disorder in line with their care plans. The dietician increased one patient's calorific intake following weight loss. The patient continued to lose weight and staff had not kept clear records of the patient's calorific intake. • Staff did not manage patient risks. Staff did not always complete observations in line with patient care plans and the provider's policy and procedures. Staff did not complete care plans for all identified risks, for example over exercising, self induced vomiting and laxative abuse. • Staff had not completed full assessments for patients with a diagnosed eating disorder prior to admission. Staff had not completed care plans that met all the needs of patients with a diagnosed eating disorder. Staff identified risk behaviours associated with the patient's eating disorder for four patients but only one patient had care plans in place to manage these risks. • Managers did not provide a safe environment for patients. The ward was not resourced with equipment required to support patients with an eating disorder.

This section is primarily information for the provider

Enforcement actions

For example, pressure relieving equipment, specialist lifting equipment or appropriate scales. A patient was in a distressed state for over an hour due to lack of specialist equipment.

This was a breach of regulation 12