

Coventry and Warwickshire Partnership NHS Trust

Specialist eating disorders service

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Ratings

Overall rating for this service

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Requires improvement 

Summary of findings

Specialist eating disorders service

Requires improvement 

Summary of this service

We rated Aspen Centre as requires improvement because:

- The trust had not ensured that effective governance was in place to monitor the quality and safety of the service. They had not supported staff to drive improvements. Senior managers had not ensured that staff were fully engaged with the running of the service. There had been no team meetings or governance meetings for many months. Managers did not routinely provide staff with feedback from incidents or share information on lessons learned. Staff morale amongst the nursing team was mixed.
- There had been significant staff shortages in the 12 months leading up to the inspection. This meant the service had relied heavily upon bank and agency nurses to fill shifts. A large number of shifts remained unfilled. Patients and families told us that the temporary staff were often unfamiliar with the ward. This meant that the patients sometimes had to explain their treatment plans to these staff. Almost half of the nursing team had recently been redeployed from another service. New staff were unfamiliar with eating disorders services. The multidisciplinary team were supportive of the new staff but senior managers had not put in place a timely induction programme to provide them with the training and professional development to undertake their duties.
- Only three out of 23 staff had received update training on the Mental Health Act and the Mental Health Act Code of Practice. The trust had assured CQC that this training would be provided by the end of March 2017 but it had not been provided.
- The service did not routinely seek patient and carer feedback.
- The service was slow to respond to maintenance issues and patient requests.
- Relatives were not told how to make a complaint.
- There were limited activities for patients to take part in during the evenings and at weekends.
- Staff did not routinely give patients a copy of their nursing care plan but patients did have copies of their treatment programme. Staff completed risk assessments for each patient but these were not regularly updated after incidents and were not linked to nursing care plans in four out of the six records we looked at.
- Patient records were hard to navigate and consecutive routine audits had noted this, but there were no action plans to remedy the problem.

However:

- Aspen Centre was a comfortable and suitable facility for patients. There was a secure door entry system to prevent unwanted visitors to the ward. Staff undertook risk assessments for each patient. Managers provided training for staff in safeguarding children and adults. Staff reported safeguarding concerns to the local authority. Families told us they believed the service was safe and patients said they felt safe. Staff managed risk well and Aspen Centre had a good track record on safety. Staff knew how to report incidents. The ward had safe systems to manage medication. There was an ongoing recruitment programme to fill vacancies.

Summary of findings

- Staff provided high quality treatment and care. They routinely supported patients to address their physical healthcare needs as well as their emotional needs. Different professionals worked well together to assess and plan for the needs of patients. Staff used specialist tools to assess the severity of patients' eating disorders. Treatment plans focused on recovery, stabilisation and rehabilitation. There were a variety of treatment programmes to suit individual patient needs. To aid their recovery, patients had access to specialist therapies. These included family therapy, psychosocial, psycho-education, relaxation, coping skills and body awareness. The treatment programmes included therapeutic goal setting. Patients also had access to social activities, which included arts and crafts sessions, weekly flower arranging, knitting, crocheting, board games and book club.
- Staff ensured that patients and families, where appropriate, were engaged with the overall treatment programme. Patients were involved in developing and updating their treatment plans and were encouraged to attend a weekly multidisciplinary ward meeting. Patients could invite family members to important meetings about their care.
- In spite of low rates for update training, staff we asked understood the Mental Capacity Act and the Mental Health Act. There were no detained patients on the ward when we carried out this inspection but the service had systems in place to store Mental Health Act paperwork and staff routinely carried out mental capacity assessments with patients.
- Staff received regular supervision and annual appraisals. There were development opportunities for staff to progress with their careers. The service carried out regular audits.
- There were no formal complaints about the service and there were high numbers of compliments.
- The service was committed to becoming accredited with the Royal College of Psychiatrists' Quality Network for Eating Disorders and had submitted their application.

Is the service safe?

Requires improvement



We rated safe as requires improvement because:

- The nursing team had been significantly understaffed in 2016. The staff turnover rate for the year 2016-17 was very high, at 53%.
- A total of 1480 shifts had been filled by bank or agency staff between April 2016 and March 2017, which represented over a third of shifts. During the same period, the trust had failed to fill 180 shifts for qualified nurses and healthcare support workers.
- Those working in the service did not learn lessons from adverse incidents that happened on the ward. Staff did not always update nursing care plans to reflect recent patient incidents. Senior managers did not support staff to learn from incidents and there were no local mechanisms for staff to learn from incidents.
- Managers had not provided staff with feedback about reported incidents. This had improved from 0% to 75%, but managers were not routinely providing feedback to staff about incidents.
- Patients said the service was slow to resolve routine maintenance problems. They had reported blocked and slow draining showers for more than 6 months.

However:

- The unit was visibly clean and clutter free.
- Staff knew how to protect patients from avoidable harm. The service had policies to protect staff and patients from avoidable harm.

Summary of findings

- Staff understood how to recognise and report safeguarding concerns.
- Staff carried out appropriate risk assessments to keep patients safe but did not always update them.
- Staff completed their mandatory training and managers monitored their attendance to ensure compliance. Compliance rates were high.
- The unit had good medication management policies in place and the pharmacy team carried out regular visits.
- Staff knew how to report incidents or risks of harm. Staff logged incidents but trust data was unclear if managers investigated them.

Is the service effective?

Good 

We rated **effective** as good because:

- Staff planned and delivered patient care and treatment in line with current guidelines, such those from the Royal College of Psychiatrists and the National Institute for Health and Care Excellence (NICE).
- In line with NICE guidelines and the Mental Health Act Code of Practice (2015), patients received thorough physical health checks and medical support to promote their overall wellbeing.
- The unit provided a multidisciplinary service by employing a range of professionals to meet the needs of their patients. The unit had a mix of staff including managers, nurses, support workers, a dietician, therapists and psychiatrists.
- Therapy plans were up-to-date, showed patient involvement and staff regularly reviewed them. Staff used outcome measures to monitor patient progress.
- Staff developed individual and group therapy programmes for patients, which gradually increased independence. As they got better, patients could manage their own meal preparation and be prepared for activities such as eating out.
- Psychological therapies, such as cognitive behavioural and family therapy were available for patients. There were no waiting lists for patients to see a therapist.
- Staff stored confidential and legal paperwork safely.
- Staff routinely obtained patient consent to treatment, then effectively recorded and stored it. Staff supported patients with decision making.

However:

- The patient record system was hard to navigate. The service had identified this in the last two documentation audits but there was no action plan in place to resolve the issue. A number of documents in the paper files were misfiled and there were loose papers in the files.
- Only three of the nursing team were up to date with training on the Mental Health Act, despite managers previously assuring CQC that this would be completed by the end of March 2017. However, the staff we asked showed an understanding of the Act.

Summary of findings

- Twelve new staff were recruited to the nursing team between December 2016 and February 2017 (over half the nursing establishment). Other disciplines were supporting the nursing team but new staff had to wait until March 2017 for a full service specific induction to eating disorders. These staff had previously worked in mental health services but had no prior experience of working in a specialist eating disorders service.

Is the service caring?

Good 

We rated caring as good because:

- We observed staff supporting patients with kindness and treating them with dignity and respect.
- Staff involved patients and families as partners in their care, treatment and rehabilitation.
- We spoke with an external professional who spoke very positively about the care and treatment provided by Aspen Centre staff.
- We observed kind and caring interactions between staff and their patients.
- Staff responded quickly and compassionately to their patients.
- Patients were encouraged to develop their independence. Staff supported them to manage their nutrition, their physical health and their emotional needs.
- Patients understood their treatment plans.
- There was an independent mental health advocacy service that was easy for patients to use.

However:

- One patient and one relative told us that some staff did not knock on bedroom doors before entering.
- Staff did not routinely seek feedback from patients and families about how they experienced the service.

Is the service responsive?

Good 

We rated responsive as good because:

- Staff assessed patients for the service in a timely manner. They kept patients, families and referrers informed about the referral and assessment process.
- The unit supported patients and their carers to achieve their goals and develop a better understanding of their needs.
- The pathway toward discharge was clear for patients and their families to understand from the outset.
- The unit was a comfortable environment. Patients could personalise their bedrooms to suit their own tastes.
- Almost all patients enjoyed the activities that were available.
- Patients could access the right care at the right time because they had a range of professionals available to support them.

However:

Summary of findings

- Patients told us there were limited activities in the evening and at the weekend. Activities were even more limited for patients who were being treated on one of the short admission programmes.
- Families said they had not been told them how to make a complaint about the service. Despite this, they were sure they could find out and felt they would be listened to if they did make a complaint.

Is the service well-led?

Requires improvement



We rated well led as requires improvement because:

- The trust did not ensure that effective governance was in place to monitor the quality and safety of the service or to drive improvements within the service.
- Staff routinely carried out regular ward based audits but there was no governance support to ensure actions were followed through.
- The service did not collect, analyse and respond to feedback from patients, families and staff. Senior managers did not support staff to deal with recurring feedback themes.
- Managers did not lead staff to learn from incidents and they provided variable levels of feedback to staff following incident reporting.
- Managers had not anticipated the impact, nor planned a thorough induction programme, for the 12 new staff they had recruited between December 2016 and February 2017. Whilst other disciplines were supportive of the nursing team during the induction period, these new staff had to wait until March 2017 for a full service specific induction.
- Morale amongst nursing staff was mixed and there was a clear split between the old and new staff team.

However:

- The leadership, governance and culture within the service was open and, despite not getting regular feedback from managers, staff routinely reported incidents.
- Staff routinely reported safeguarding concerns.
- Staff were confident they could speak up if they had concerns.
- Local managers were visible and available to staff, families and patients.
- The service had applied for accreditation with the Royal College of Psychiatrists' Quality Network for Inpatient Eating Disorders.

Detailed findings from this inspection

Is the service safe?

Safe and clean environment

- There was a secure entrance to Aspen Centre. Staff let people in and out of the unit. The main entrance and reception area was shared with the outpatient eating disorder service. Staff used swipe card to access non-patient areas.
- Staff carried out annual environmental audits of ligature risks, which identified areas of risk within the building. A ligature is an anchor point that someone could tie something to in order to harm themselves. The last two audits did not identify any new risks and the action plans showed that existing risks would be managed. Staff carried out regular risk assessments for individual patients to monitor their safety within the environment. Staff provided increased levels of observations if they assessed that patient risk had increased. One patient bedroom was designed with anti-ligature fittings to accommodate a patient with heightened risk.
- The service became a single gender unit in 2016. At the time of this inspection, all patients were female so the ward complied with Department of Health guidelines on same sex accommodation.
- The ward layout allowed staff to observe all parts of the ward.
- The clinic room and treatment room were visibly clean and well ordered. Staff could find what they needed when they needed it. We inspected a sample of cleaning log checklists and found they were up-to-date and there were no gaps. The ward manager undertook audits to ensure staff carried out these checks. Emergency equipment, including defibrillators and oxygen, was accessible to staff and they checked it each day to ensure it was fit for purpose and ready to use in an emergency. Records showed staff regularly maintained and serviced equipment in line with manufacturers' guidelines. This meant the clinic room and treatment room were managed safely and effectively.
- The unit was visibly clean. The 2016 Patient-Led Assessment of the Care Environment (PLACE) score for cleanliness was 100%. This was higher than the trust average of 97% and higher than the England average of 98%. PLACE assessments are self-assessments undertaken by teams of NHS and independent healthcare providers. The teams include at least 50% members of the public (known as patient assessors). They focus on different aspects of the care environment. Staff were carrying out routine cleaning during the inspection and told us they had the equipment they needed to do their job well.
- Corridors were clear and clutter free. The communal lounge was cluttered and access to the computer chairs was somewhat restricted by a sofa. The 2016 PLACE score for general building maintenance was 99%, which was higher than the trust average of 94% and higher than the England average of 93%. However, at the time of this inspection, there was evidence of mould in one bathroom, which patients had reported to staff. Patients told us that maintenance and repairs to the unit were not carried out in a timely manner. Records showed that patients regularly reported the same issues. The ward manager agreed to look in more detail at how the service monitored maintenance requests.
- Patients and relatives told us the unit was always clean and tidy.
- Patients were responsible for keeping their rooms in order but domestic staff carried out the cleaning. The bedrooms we looked at were visibly clean.
- Staff encouraged good hand hygiene in the unit. They displayed hand hygiene signs and sinks were available for patients, visitors and staff to use. However, there was a hand sanitiser unit at the entrance to the ward and at the garden door, neither of which were working. We asked staff about this and they showed us that they carried their own hand sanitiser. Staff carried out a patient satisfaction questionnaire for January to June 2016. Feedback given in the last patient satisfaction questionnaire said that hand gel dispensers should be installed for patients, visitors and staff

Detailed findings from this inspection

to use. The trust told us one of the units had stopped working in November 2014 and the other unit was not broken but needed refilling. A manager told us the units were out of use because the gel was no longer deemed suitable for the ward environment. The trust told us both hand sanitiser units were replaced within a week of this inspection taking place.

- To protect against the risk of infection, staff carried out regular infection prevention and control audits. The service scored 100% for each hand hygiene audit between May 2016 and April 2017. Estates staff regularly inspected and cleaned the water system to make sure it was clean and safe for patients and staff to use. We observed a technician carrying out these checks during the inspection.
- To reduce incidents of injury and infection, staff disposed of sharp objects, such as used needles and syringes, appropriately. The service carried out regular audits of sharps disposal. They scored 96% in the most recent audit.
- The unit carried out regular safety tests for electrical items. We looked at a sample and found they were up-to-date.
- Nursing staff carried personal alarms to summon help in an emergency. Toilets and bathrooms had call alarms so patients could summon help in an emergency. Other members of the staff team and visitors could obtain a personal alarm from reception. Reception staff managed the testing and charging of the alarms.

Safe staffing

- Establishment levels during the day were three qualified nurses and three healthcare support workers. At night, it was two qualified nurses and one healthcare support worker. The service did not include the ward manager in the staffing establishment. The ward manager had authority to increase staffing levels based on patient need.
- The service had reduced patient admissions from 15 to 12 in 2016 because of short staffing in the nursing team. The manager had left in May 2016 and large number of nurses and health care support workers left throughout 2016, with a significant number leaving in December 2016. Recruitment to these posts had not taken place until December 2016 and early 2017 when 12 new staff started, 10 of whom moved to Aspen Centre as part of a trust redeployment plan.
- Between April 2016 and March 2017, a total of 729 shifts were filled by bank staff and a further 751 shifts were filled by agency staff. There were 180 unfilled shifts, 91 of which were for qualified nurses. Staff completed 73 incident reports relating to staff shortages.
- Patient feedback showed that between January and June 2016, patients reported there were not enough staff to support them, staff did not have time to engage with them effectively, activities were cancelled due to a lack of staff and it was difficult for them to find a permanent member of staff to talk to. The patient satisfaction questionnaire also highlighted that new and agency staff did not demonstrate a basic understanding or insight into eating disorders. There was no evidence that managers had listened to or acted upon this feedback. When we carried out this inspection, patients and families still reported issues with staffing levels and the lack of suitably trained staff to carry out nasogastric feeding. However, they said things had improved since December 2016.
- There were 4.4 whole time equivalent vacancies for nurses and one vacancy for a healthcare support worker. The service had appointed to one of the nurse vacancies and had received applications for the other posts. The new ward manager had gained approval to retain three agency nurses on long-term contracts, with the aim of ensuring the ward was staffed by nurses who were familiar with the staff team, patients and ward procedures.
- Staff turnover in the 12 months prior to the inspection was high at 53%. Some staff had left to move to a newly opened facility in the area.
- Sickness absence rates were at 7% compared to the trust average of 5.4%

Detailed findings from this inspection

- Staff had undertaken mandatory training relevant to their role, including safeguarding children; safeguarding adults; fire safety; health and safety; moving and handling; Mental Capacity Act; Mental Health Act; basic and immediate life support; infection control; and management of potential or actual aggression.
- At the time of the inspection, mandatory training compliance was high at 93%.
- Staff received an induction to the trust and to the unit. The induction process also covered issues specific to the field of treating patients with eating disorders. Due to the high volume of staff redeployed to the service, the normal individual induction process was replaced with group learning and development sessions developed by the ward consultant and senior members of the multidisciplinary team. These sessions began in March 2017, three months after some staff came to work at Aspen Centre.
- Staff told us there was adequate medical cover day and night to provide routine and emergency care.
- As part of the treatment programme, staff supported patients to take leave away from the unit. Staff, patients and families told us leave was rarely cancelled because of staff shortages but activities had been frequently cancelled when the unit was short staffed. Patients received their 1:1 time with staff. This had improved in time and frequency since more nursing staff had been recruited.

Assessing and managing risk to patients and staff

- Aspen Centre did not practice seclusion or long term segregation.
- Staff rarely used restraint and if they did, they recorded this as an incident. The service did not practice prone restraint, which is a restraint where staff place the person face down on the floor. Patients told us they had not been subject to restraint at the unit and families confirmed this. There were no recorded incidents of restraint in the six months leading to the inspection.
- Patients, relatives and staff told us they felt safe on the unit.
- Staff used a recognised risk assessment tool for all patients. Risk assessments were clear but were not always linked to individual care plans. Staff routinely assessed patients before they took leave and when they returned to the unit. Each of the six case records we looked at had a risk assessment. Two of these were thorough with clear risk management plans and were linked to nursing care plans. Four were not linked to nursing care plans. One care record showed three recent incidents of deliberate self-harm but staff had not reflected this in the risk assessment or risk management plan.
- Risk assessments did not include formal crisis plans but had brief statements advising patients to contact the ward if they needed support when they were on leave.
- Patient records did not have advance decisions indicating how they would like to be treated if they became mentally unwell in the future.
- Staff had all received training in safeguarding adults and children. Staff routinely considered safeguarding and sent safeguarding concerns to the local authority when necessary.
- Aspen Centre had policies to manage risks, such as a list of items that were not allowed on the unit, safeguarding, internet use, mobile telephone use and a search policy.
- The service had blanket restrictions in place. This means there were restrictions that applied to all patients, regardless of their individual risk. These restrictions were in place to support patients with managing their eating disorder and to increase the likelihood of patients reaching a healthy weight. Restrictions included locked door access to the garden, internet access and mobile telephone use on the ward. These restrictions were justified for the purposes of supporting patients through complex treatment programmes for people with eating disorders.

Detailed findings from this inspection

- The service had an observation policy, which staff used to ensure they monitored patient risks while on the unit.
- Staff used handovers to share information about risks and incidents. They used a handover book to record information for each patient, which they passed to staff beginning the next shift. They also used a ward round book which captured details of the weekly multidisciplinary meetings, which staff used to complete entries in the patient records.
- We reviewed the medicine administration records of 12 patients at the unit. Staff managed these records effectively. Incident reporting data showed that if staff made errors in administering medication, they recorded these as incidents. The service had safe and effective medication procedures. Staff identified when errors in medication administration had occurred. The ward consultant monitored medication regimes carefully because of the physical health complexities associated with eating disorders. The ward consultant had worked with the local area prescribing committee to develop a protocol for the treatment of vitamin D deficiency in anorexia nervosa. The ward consultant had also worked with the local hepatology and pharmacy departments to develop guidance for the prescribing of paracetamol. These supported on call doctors, who may not be familiar with the patient group at Aspen Centre.
- Aspen Centre received regular weekly visits from the pharmacy team who provided oversight of their medication management system.

Track record on safety

- In the 12 months prior to the inspection, there were no serious incidents that required investigation. The service kept detailed records of all incidents.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents of harm or risk of harm. They were confident they could report incidents. Aspen Centre had clear incident reporting procedures and these were easy for staff to follow.
- While the unit had been short staffed and without a ward manager, from May-December 2016, the service provide limited feedback to staff about incidents. The trust had not given any feedback to staff in August and September 2016. Managers gave staff feedback in 10 and 11% of incidents in October and November 2016. Feedback to staff was improving since the unit had appointed a new ward manager and stood at 75% in March 2017.
- The trust sent out lessons learned email bulletins to staff. However, the service had not been holding team meetings or governance meetings for many months, so there was limited opportunity for staff to discuss local lessons learned from incidents and complaints.

Is the service effective?

Assessment of needs and planning of care

- The multidisciplinary team carried out thorough individualised patient assessments. They used specialist assessment tools designed for patients with eating disorders. Treatment plans addressed individual patient needs. They were holistic, covering all aspects of patient need. Staff reviewed and updated the treatment plans regularly. Patients also had nursing care plans, which supported their overall therapy programme. Each element of the multidisciplinary team worked together with patients to provide the therapy programme. Each patient had a named nurse.
- Therapy, medical, nursing, physiotherapy, dietetic and occupational therapy staff worked together to plan and deliver patient care. They maintained contact with the patients' home teams, commissioners, GPs and families. Treatment and therapy plans were clear and holistic. They looked at all of the patients' needs. Nursing care plans were not detailed, and were not linked to risk assessments in four out of the six records we looked at.

Detailed findings from this inspection

- During the day, nurses and other members of the multidisciplinary team supported patients to attend activity and therapy sessions.
- The staff office had a white board, which contained essential patient information. The board had doors, which protected personal information. This was new to the ward and staff had reassured patients that no sensitive information would be on view. Staff stored patient records securely. However, files were difficult for staff to navigate and some had loose papers inside with hand written instructions on sticky notes. The trust was in the process of changing the electronic patient records system. Staff at Aspen Centre had a mix of paper and electronic patient records. This meant that patient information was stored in more than place. The trust was supporting staff to learn how to use the new system.

Best practice in treatment and care

- In line with the National Institute of Health and Care Excellence (NICE) staff followed “Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition” (2006) prescribing guidelines.
- Aspen Centre followed NICE guidelines and provided a range of psychological and family therapies for patients. The service employed psychologists, therapists and a nurse therapist. There were no waiting lists for psychological interventions. Patients could access cognitive behaviour based therapies designed for people with eating disorders. Individual and group therapies were available to patients. Relaxation, coping skills and psycho education groups helped patients learn resilience and coping strategies to support their recovery.
- In line with NICE guidelines and the Mental Health Act Code of Practice (2015), staff identified and managed patients’ physical healthcare needs. Staff made sure that patients were referred for specialist investigations and treatment when they needed it. To manage risk of falls and pressure ulcers, patients could access physiotherapy and tissue viability services when they needed to. The service provided pressure relieving mattresses if patients needed them.
- Families told us staff monitored and supported their relatives with physical healthcare. They were confident with the care provided.
- The service admitted patients requiring nasogastric feeding and there was a training programme in place for new nursing staff to administer this procedure. However, staff had to undertake three supervised procedures before they were able to carry it out independently. The ward manager was looking at ways of managing this because the procedure was not commonly used at the unit, which meant staff were struggling to carry out their minimum requirements.
- The unit had a no smoking policy. Patients could access smoking cessation support if they wanted to.
- Aspen Centre used standardised and specialist assessment tools such as MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) and the Eating Disorder Examination Questionnaire (EDEQ). They used Health of the Nation Outcome Scales (HoNOS), CORE outcome measure (CORE-OM) and Diabetes Quality of Life Measure (DQOL). Staff followed NICE Guidelines “Eating disorders in over 8s: management” and were awaiting publication of the revised NICE guidelines for eating disorders. Therapy staff completed the Eating Disorder Examination Questionnaire when patients were admitted and again when they were discharged. This meant patients and staff could measure the outcomes of treatment plans.
- Clinical staff carried out regular clinical audits.

Skilled staff to deliver care

- The staff working at Aspen Centre came from a range of professional backgrounds including nursing, medical, therapy, dietetics, hospitality, family therapy, management and catering. Out of hours medical care was provided using the local on call rota. There was a dietician and a dietetic assistant to support patients with meal prescription

Detailed findings from this inspection

plans and nutritional guidance. There were occupational therapists who worked closely with patients to support them through their treatment programme and a physiotherapist regularly attended the unit to assess and support patients. The unit could access a tissue viability service but there were difficulties at times due to commissioning issues.

- Routinely, new staff received an induction to the unit, which included training sessions related directly to the specialist area of eating disorder and time spent with each professional discipline to understand the role of the whole multidisciplinary team. As a result of the staff shortage in the nursing team and the introduction of 12 new staff between December 2016 and February 2017, there was not enough capacity to enable each new member to have this type of induction. The ward consultant and other senior members of the multidisciplinary team devised and ran three half-day onsite training sessions for the new staff during March 2017. Seven nurses and five health care support workers attended these sessions. The multidisciplinary team were committed to supporting the professional development of the new nursing team.
- We asked the trust to supply information about specialist training available to staff which was specific to eating disorders. The trust did not supply this information but did provide detail of the induction training developed by the ward consultant and senior multidisciplinary staff. The trust also supplied details of the continued professional development programme available to staff from July 2016 to May 2017. The programme was specific to eating disorders and included sessions on radically open dialectical behaviour therapy, self-harm and new treatments in anorexia nervosa.
- The service operated a supervision tree arrangement. This meant that staff received management supervision from a colleague in the grade above. Trust data showed that 65% of staff at Aspen Centre received management supervision in the two months leading up to the inspection. Staff were also able to access clinical supervision. If there was no one within the trust to provide supervision for an allied health professional, perhaps because they were the most senior grade, the trust arranged for an outside agency to provide the supervision. We looked at a sample of three supervision records and saw that staff were receiving supervision.
- Trust data showed that 92% of staff had received an appraisal. This was below the trust target of 95% but above the trust average of 85%. Managers were able to tell us how they dealt with issues of poor staff performance when they needed to.
- Health care support workers could study toward the Care Certificate. The Care Certificate was introduced in 2015 and aims to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. Only one member of staff had completed the Care Certificate. Five had completed National Vocational Qualification level three before transferring to the unit and one was studying for a National Vocational Qualification at the time of the inspection.

Multi-disciplinary and inter-agency team work

- Multidisciplinary meetings (MDTs) and Care Programme Approach meetings (CPAs) took place regularly and patients routinely attended. The multidisciplinary team met twice every week, so each patient received a weekly review of their treatment. Patients were included in these meetings and were encouraged to provide written summaries of their week, their concerns and any special requests they wanted staff to consider. Families and carers attended the CPA meetings if patients wanted them to be included. Families told us they received written records of the meetings. The advocacy service was not routinely involved in CPA meetings and ward rounds.
- Patient records showed there was effective multidisciplinary team (MDT) working taking place. We observed a multidisciplinary meeting and staff demonstrated that they worked well together and considered patients holistically.

Detailed findings from this inspection

- Staff maintained close links with patients' GPs and community teams, advising them of important issues. Staff sent clear summary information to GPs when they admitted and discharged patients from the service. An external professional told us the service involved them in important patient meetings and the service planned patient discharges effectively.
- The different professions appeared to work well together and showed mutual respect for each other. However, some staff told us that the recent intake of a large number of staff from a different service into the nursing team, had led to some problems.
- Staff used handovers to share information about risks and incidents. The nursing team also used a communications book to share important information. However, we looked at the communications book and found 11 out of 12 recent entries were undated. It was not clear when things had been actioned.

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

- Aspen Centre admitted patients who were detained under the Mental Health Act but most patients were admitted informally. The last detained patient was discharged in February 2017. There were no detained patients on the unit when we carried out the inspection.
- Staff understood their responsibilities under the Mental Health Act.
- Staff stored legal paperwork securely.
- Staff knew how to get advice about the Mental Health Act if they needed it and the Mental Health Act team regularly visited the unit.
- Staff received training in the Mental Health Act as part of their induction. Following the scheduled Mental Health Act monitoring visit in July 2016, the trust provided CQC with an action statement. The action statement said staff would receive updates on the Mental Health Act and the Mental Health Act Code of Practice by the end of March 2017. At the time of this inspection, only three out of twenty three staff were up-to-date with their Mental Health Act training updates. Managers told us a new training schedule had been developed and staff would soon complete it.
- The trust carried regular audits of the Mental Health Act function but Aspen Centre had not been included in these recent audits because they did not have any detained patients when the audits were carried out.
- An independent mental health advocate visited the ward each week. We looked at staff information about the advocacy service and saw that staff believed the advocate role was to support patients with issues such as welfare benefits and housing. The advocacy service confirmed they were commissioned to support detained patients with their rights under the Mental Health Act. There was a separate advocacy service in the area for patients to get support with generic advocacy services but there was no information on the ward about that service.

Good practice in applying the Mental Capacity Act

- When we carried out this inspection, all patients at the unit were there informally.
- Adults who are in hospital can only be detained against their will if they are sectioned under the Mental Health Act or if they have been deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS). If patients are not subject to the Mental Health Act and Mental Capacity Act, they can leave the unit, so need to know their rights. Patients we spoke to knew their rights. They knew they were free to leave the unit if they wanted to. Staff displayed signs on the unit advising patients of their right to leave.
- Staff completed capacity to consent to admission and treatment forms with patients when they were admitted to the ward. They reviewed these at regular intervals.

Detailed findings from this inspection

- Staff demonstrated a good understanding of the Mental Capacity Act and could give examples of decision specific assessments. We saw examples of staff supporting patients with decision specific capacity assessments. In line with the Mental Capacity Act, staff assumed patients had capacity unless they were given cause to doubt it.
- As part of their induction, staff received Mental Capacity Act training including Deprivation of Liberty Safeguards. At the time of the inspection, only three out of twenty three of the nursing team were up to date with their refresher training in the Mental Capacity Act. However, the staff we asked showed an understanding of the Mental Health Act.
- Staff knew who to contact for further advice and guidance about issues relating to the Mental Capacity Act.

Is the service caring?

Kindness, dignity, respect and support

- We observed staff interacting with patients in a caring and compassionate way. Staff responded to patients in a calm and respectful way. Staff interactions appeared to be caring and supportive.
- Patients and relatives told us staff always treated them with kindness and respect.
- We talked to staff about patients and they discussed them in a respectful manner and showed a good understanding of their individual needs. Feedback from one patient in 2016 had showed they felt staff listened to them, they felt supported and had been involved in their care.
- Patients were able to approach staff freely when they wanted help and support.
- Patients and their families told us they believed staff were genuinely interested in their wellbeing. A number gave positive feedback about the new ward manager.
- Families were welcome to visit the unit and they told us that staff always treated them with dignity and respect.
- Three out of the four patients we asked said staff always knocked their bedroom door before entering. One patient said some staff knock but others do not. One relative told us that not all staff knocked on their relative's door and this had been uncomfortable for the patient who was in the shower when a member of staff came into the room.
- One external professional told us patients had said there was not very much privacy at the unit because sometimes staff had to observe patients when they used the bathroom. However, close monitoring of patients is generally required for specialist treatment to be fully effective, even though this can feel intrusive at times for patients. The PLACE score for privacy, dignity and wellbeing was 96%. This was higher than the trust average of 92% and higher than the England average of 85%.

The involvement of people in the care they receive

- For planned admissions, Aspen Centre provided patients and their families with information about the service before they were admitted to the unit. The service had a dedicated page on the trust website, which showed where the unit was situated, and the patient group treated there. The webpage had a link to car parking information but no other information.
- Patients agreed a written list of people they were willing for staff to share information with.
- Occupational therapy and dietetic staff encouraged patients to be involved in developing their care plans and in goal setting. Patients had copies of their treatment programme and knew at which point on the programme they were. Some patients had copies of their nursing care plans. We observed a multidisciplinary ward and patient meeting. We saw evidence that patients were encouraged to provide written and verbal feedback about their progress. Staff gave patients time to express themselves. These meetings took place each week. Feedback from an external professional

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said that a patient had suggested they would like more space to write their feedback and some had said the multidisciplinary meeting could be intimidating because there were a lot of professionals there. However, staff told us that patients were given the option of receiving feedback from the multidisciplinary ward meeting on a one-to-one basis, if they preferred.

- An external professional told us that patient meetings were well organised and well managed. Another told us the meetings were organised and contained the right group of professionals.
- An independent mental health advocate routinely visited the unit each week. The trust commissioned this service differently, depending upon whether patients had a Coventry or a Warwickshire GP. There was a poster advertising the advocacy service but no details explaining to patients when the advocate would be at the unit or what kind of support they could provide. We spoke with the advocacy service who told us that occasionally staff would email them and ask them to see a specific patient but they rarely completed formal referrals for patients. The advocacy service told us that staff understanding of advocacy, and the support a mental health advocate could provide, had recently begun to improve. Patients told each other about the advocacy service.
- Families said staff always returned their calls when they contacted the unit. They said they were able to make appointments with the ward consultant if they needed to discuss their relative's care. They said staff had explained how sharing information depended on what the patient agreed could be shared. Families told us their relative invited them to meetings. The ward consultant regularly liaised with patients' families and colleges to ensure patients received support to continue their education if necessary.
- Nursing staff and patients held weekly community meetings. Nurses made a written record of the meeting in a designated book, identifying issues patients had discussed. We looked at the book and found it mostly contained information about building maintenance requirements such as blocked showers and squeaky beds. Staff did not record what they did with the issues patients had raised. There was also a book for patients to record these meetings. However, the book had been full for many months. It was tatty, and was overflowing with loose pieces of paper because there was no space left to write in it. We found that patients had repeatedly brought a number of issues to the meeting during the preceding three months, including slow draining showers, out of order pay phone and a request to provide night-lights on the ward after lamps had been removed for health and safety reasons. The payphone had been out of order between 27 March and 2 May 2017. As part of the treatment programme, patients had restricted access to personal mobile telephones so their ability to remain in contact with friends and family would have been affected during this time.
- We looked at the most recent patient satisfaction survey for January to June 2016. The survey also identified slow draining showers was an issue for patients along with mould in some bathrooms. We identified mould in a bathroom when we carried out this inspection, which means it was possible that the mould had been in place for over a year and despite patients raising the issue, it had not been dealt with.
- The service did not routinely encourage patients and families to provide regular feedback about the service. The service did not display "You said, We did" information to show how they had responded to patient feedback. One patient had used the Friends and Family Test feedback process in 2016 and reported a positive experience. We looked at a patient feedback / survey folder but it was empty.
- Patients were not involved in updating the patient information leaflet or information pack but could be involved in showing people around the unit when they came to visit. Patients were not involved in staff interviews.

Is the service responsive?

Access and discharge

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- Most patients were admitted from the local area but the unit also accepted patients from other parts of the country. Staff carried out home based pre-admission assessments. The senior occupational therapist and senior specialist nurse did these. Patients also met with the dietician prior to admission. The ward consultant arranged ward based pre-assessments for out of area patients. The service was able to arrange emergency admissions if necessary.
- The service admitted 43 and discharged 21 patients between April 2016 and March 2017.
- Average length of patient stay at Aspen Centre was 100 days for the year April 2016 to March 2017. The service had capacity to treat 15 patients. However, they had agreed to take no more than 12 patients until they had effectively resolved the staffing shortage.
- There were no reports of patients not having access to their room on return from leave.
- We saw no evidence of patients having to move units because of non-clinical reasons.
- Staff planned discharge arrangements in collaboration with patients and their families as well as with their community teams. There were no reported delayed patient discharges but staff said these could occasionally arise if there were difficulties in community teams providing the right support or if a patient required support from external agencies such as local housing departments. If such delays did occur, these were due to circumstances beyond the control of Aspen Centre. The service planned patient discharges at appropriate times of the day. Staff recorded any transport arrangement difficulties as incidents.

The facilities promote recovery, comfort, dignity and confidentiality

- Aspen Centre had a full range of rooms and equipment suitable for the environment and patient group. This included space for therapeutic activities, relaxation and treatment. The rooms were light and spacious. Furniture was comfortable and modern. Staff displayed some patient artwork on the unit.
- There was a communal lounge where patients could meet with each other, sit and read or play board games. There was a room patients could use for activities or quiet space.
- Patients and families told us that visiting usually took place in patient bedrooms because this is what they preferred. Patients could also use the garden area with their visitors and if they needed a private room, staff could arrange this.
- Therapy rooms and offices had good sound proofing which meant private conversations could not be overheard.
- Six bedrooms were ensuite with a toilet, sink and shower. The service had designed one large bedroom for a patient with highly complex physical health needs should they require specialist equipment in the room. They had designed another with anti-ligature fittings. There were bathrooms and toilets for rooms without ensuite facilities. Outside of designated meal and therapy time, patients could access their rooms freely. Patients could personalise their rooms and use their own bedding if preferred. However, there was some confusion over the use of personal bedding because the patient leaflet stated this was not allowed, but staff told patients they could bring their own bedding if they wished to.
- Patients could lock away private possessions.
- Patients could manage their own laundry if they were able to. There was a laundry room for them to use. The trust provided guidance on their website to relatives who were managing laundry for patients.
- There was a payphone in a corridor near the door to the garden. It was not a private area for patients to hold telephone conversations. It was a busy area near to the lounge, ward manager's office and the staff office. The payphone had been out of order between 27 March and 2 May 2017. Patients had restricted access to personal mobile telephones so their ability to remain in contact with friends and family would have been affected during this time.

Detailed findings from this inspection

- The nature of the unit, and individual specialised treatment plans, meant patients were not able to have a wide choice in the menu. However, patients were able to have a list of three “dislikes” foods and staff respected this. The dietician also catered for patients who had additional special dietary requirements. Food was not freshly cooked on the premises but was frozen or reheated. Patients and families told us the food was generally good. There were no PLACE scores for food for this service. Therapy plans included time out in the community for patients to engage in therapeutic social eating.
- Patients who were progressing through their treatment programme could make meals and snacks with staff in the therapy skills kitchen. Staff supported them with meal planning, purchasing ingredients and preparing meals. The service had introduced a “come dine with me” programme for patients. There were plans to include family members in this therapy activity.
- In line with the treatment programme, patients did not have access to make drinks and snacks 24 hours a day. However, staff supported patients to manage their nutrition and hydration in line with their individualised treatment programmes.
- Patients could make suggestions for activities at the weekly community meeting. Staff supported patients to set up a book club following a patient suggestion. One family member said their relative did flower arranging once a week and had learned to knit and crochet whilst being a patient at Aspen Centre. Patients told us they enjoyed the weekly flower arranging session. There were very few staff supported activities at evenings and weekends. Some patients said the activities needed to be improved. The most recent patient feedback survey identified that activities were limited and were sometimes cancelled due to short staffing. Patients told us that activities had not recently been cancelled due to short staffing. Depending on the nature of their admission and the agreed treatment programme, some patients were only at Aspen Centre for a short time. This naturally limited their access to recreational and therapeutic activities. This was because they were either too unwell to participate or their admission status meant it was not appropriate for them to engage in long term ward based therapies. Consequently, patients told us that those who were there for only a short admission had even more limited access to recreational activities than those who were there for a longer admission.
- Staff routinely supported patients with prescribed exercise activities such as walking and swimming.

Meeting the needs of all people who use the service

- Aspen Centre was accessible for people who used wheelchairs. Some patients were physically weak when they were admitted so were assessed for mobility equipment if they needed it. The PLACE score for the environment in relation to disability was 85%. This was below the trust average of 87% but above the England average of 79%.
- Staff at Aspen Centre were able to have leaflets and care plans translated into other languages if they needed to. They could access trust wide interpreting and translation services if they needed to. At the time of this inspection, there were no patients who required this. Families told us that all information was provided in a format which was accessible to them.
- Staff respected patients’ diversity and human rights. They received training in equality and diversity. At the time of the inspection, 100% of staff had completed this training. There was no multi-faith room on the unit but patients could use their rooms for private worship or staff could support them to use the local hospital multi-faith chapel if they wanted to. This was situated on the same site. Staff routinely supported patients to meet their spiritual needs.
- The service could meet individual cultural and religious dietary needs within the treatment programme. They provided a vegan diet for patients who had a cultural need.
- The service was accessible to pregnant women.
- The service was accessible to patients with complex physical health problems.

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- Staff maintained a large noticeboard on the ward, which contained a variety of information including support options, advocacy and substance misuse services. They displayed information about the complaints process but it was not easy to find on the noticeboard. There was no suggestion or comment box for patients and families to use.

Listening to and learning from concerns and complaints

- Families said staff had not told them how to make a complaint. However, they were sure they could find out and felt they would be listened to if they did make a complaint. Two families told us they had raised concerns and staff had dealt with them effectively. The service had received no formal complaints between April 2016 and March 2017 but had received 21 compliments.
- Patients could raise concerns and complaints in the community meetings or by submitting a formal complaint. Patients could also raise concerns directly with staff.
- Staff carried out a documentation audit, which recorded if staff could explain the complaints procedure and if patients were aware of it. Staff carried out the most recent audit in March 2017. It recorded that staff could explain the complaints procedure but identified that patients were only partially aware of the complaints procedure and / or there was partial evidence in the community meeting minutes.

Is the service well-led?

Vision and values

- Staff were clear their role was to provide good, person centred care and to support patients through the treatment programmes until they could be discharged. Staff were aware of the trust values: compassion in action, working together, respect for everyone and seeking excellence.
- Staff knew the trust chief executive and newsletters showed that the chief executive was willing to meet local teams. Some staff could recall the chief executive visiting the service.

Good governance

- Managers could access a dashboard, which showed staff compliance with statutory and mandatory training. There was a clear programme for this training. Trust data showed that compliance with this training was 93% for the nursing team. The trust did not supply data for the service as a whole.
- Managers made sure that staff had regular supervision and annual appraisals in line with trust policy.
- Staff had opportunities to take part in clinical audits within the service. Staff carried out a number of routine audits relating to processes and procedures.
- Staffing of the nursing team had been particularly problematic. The manager had left in May 2016 and large number of nurses and health care support workers had left throughout 2016 with a significant number leaving in December 2016. Recruitment to these posts had not taken place until December 2016 and early 2017 when 12 staff started, 10 of whom moved as part of a trust redeployment plan. Between April 2017 and March 2017, there was high use of bank and agency staff. A large number of shifts were not filled at all, which meant that the unit did not have the planned number of staff on duty. Staff completed a total of 73 incident reports relating to staff shortages.
- Patient feedback relating to the availability of staff, showed that between January and June 2016, patients reported that there were not enough staff to support them, staff did not have time to engage with them effectively, activities were cancelled due to a lack of staff and it was difficult for them to find a permanent member of staff to talk to. The

Detailed findings from this inspection

patient satisfaction questionnaire also highlighted that new and agency staff did not demonstrate a basic understanding or insight into eating disorders. There was no evidence that managers had listened to or acted upon this feedback. When we carried out this inspection, patients and families still reported issues with staffing levels and the lack of suitably trained staff to carry out nasogastric feeding.

- Staff told us they felt able to report incidents and raise concerns without fear of recrimination, which indicated an open culture. We looked at a sample of incident reporting from October 2016 to March 2017. We saw that staff regularly reported incidents and that managers reviewed them. However, there were a high number of incidents relating to nursing shifts not being covered and a number where patients were unable to receive planned nasogastric feeding because there were no suitably trained staff available to carry out the procedure. These incidents clearly frustrated and concerned staff. In August and September 2016, the percentage of incident reports where managers provided feedback to staff was 0%. This increased to 10% in October 2016 and 11% in November 2016. These low feedback rates were despite staff having specified in the incident report that they had informed the head of patient safety and assistant director of nursing of some incidents. The rates increased to 92% in January 2017 with the appointment of a new ward manager but had fallen to 75% in March 2017.
- The trust sent out regular learning alerts to staff to support with learning from incidents across the trust. However, there was no evidence that senior managers provided analysis and learning from incidents within the service. For the year April 2016 to March 2017 staff routinely reported incidents but received little, if any, feedback from managers. Senior leaders did not demonstrate that they supported staff to learn from incidents that had occurred within the service. There were no improvement plans in place other than to resolve the shortage of nursing staff.
- The trust had a duty of candour policy, which staff understood and adhered to. The duty of candour requires providers to be open and transparent with patients when something has gone wrong. Staff understood that if they made mistakes, it was important to be open and transparent with patients and their families. One relative gave an example of a time when staff had been open and transparent with them because there were no suitably experienced staff available to carry out a care planned procedure. We saw other evidence that staff adhered to their duty of candour responsibilities when they investigated an incident.
- The trust had received no complaints about the service in the 12 months leading up to this inspection. The service had received 21 compliments.
- The service had access to a wide range of centralised trust policies to support with governance. These policies were designed to protect patients and staff. The trust had updated most of the policies we looked by the scheduled review date. However, the child visiting policy had not been reviewed by the due date of July 2016. The policies were easy for staff to locate on the trust intranet.
- Aspen Centre staff carried out regular ward based audits. Audits included infection prevention and control, medication management, mattress, sharps, ligature risks, environmental and case recording. Between February 2016 and March 2017, staff carried out three documentation audits. These looked at areas including a sample of patient notes, ward governance, staff supervision and routine audits. None of the audits identified what action would be taken when areas for improvement were identified. For example, in each of the three documentation audits it was identified that staff were not following the correct filing structure for the notes. The audit tool changed in August 2016 to include a prompt “are the notes easy to navigate?”. In both the August 2016 and March 2017 audit, the four patient records staff audited showed that the notes were not easy to navigate but there was no plan to address the issue. We looked at six sets of patient notes as part of this inspection and found the paper files were not easy to navigate. Additionally, each of the audits showed that ward governance meetings were not taking place but there was no plan to address this.

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- The ward manager had enough time and autonomy to manage the ward effectively. They had the authority to book additional staff for the ward. They met regularly with their line manager and the ward consultant. They had identified that no staff team meetings or governance meetings had taken place for some time. They planned to reinstate these. The ward manager was relatively new in post and had some plans for improvement in the running of the ward.
- Staff were able to submit items to the trust risk register and the shortage of nursing staff had been recorded.

Leadership, morale and staff engagement

- The trust carried out an annual staff survey and used the data to benchmark themselves against other trusts, to celebrate improvements and to identify areas for further improvement. To provide a level of anonymity, the survey did not show staff responses for individual trust services. The respondent rate was 43%. One area the trust identified for improvement was feedback from senior managers. The survey showed that only 33% of the respondents felt that senior managers acted on feedback provided by staff. Staff told us they could provide feedback locally within the service but there was a disconnect between them and senior managers. Some felt this was due to a number of senior management reorganisations in recent years.
- There was evidence of clear leadership provided by the ward consultant who was engaged and supportive of the whole multidisciplinary team. This leadership was central to the cohesive function of the multidisciplinary team, which effectively supported the treatment programmes. The team worked well together and maintained stability through a difficult period of change within the nursing team.
- There was evidence of new leadership for the nursing team since the appointment of a new ward manager in January 2017 and a deputy ward manager in May 2017.
- The trust told us that a general manager had been appointed in March 2017. The trust organisational chart showed this manager had overall responsibility and accountability for this and a number of other trust services. However, staff told us there was no single manager with responsibility for the whole service. Staff told us that the different aspects of the multidisciplinary team had different managerial lines of accountability. This meant that staff had to negotiate a host of different senior managers to drive improvements within the service. There was no evidence that managers at a senior level provided a holistic support to the service. The ward manager and consultant were visible during the day-to-day provision of care and treatment and were accessible to staff, patients and families. The ward manager was accountable to the pathway manager, who regularly visited the unit and was available to staff and patients. The chief executive made occasional visits to the unit. There were no reports of other senior managers, who had the capacity to support staff with important organisational decisions, visiting the unit or being involved in the day-to-day management and running of the service.
- There were no reported incidents of staff harassment or bullying. Most staff told us they felt supported and valued by their immediate line manager.
- Staff knew about the whistleblowing process and felt confident they could use it if they needed to. They were confident they could raise issues of concern without fear of victimisation and some staff told us they had done so.
- Morale at Aspen Centre was mixed. Staff from all areas of the service told us they enjoyed working there and were committed to providing quality care and support to patients. One member of staff told us the induction arranged by the ward consultant was much better than they had received in other places. However, a number of staff told us the service was very busy and some felt they need to work extra, unpaid hours, to keep up with the workload. The introduction of 12 new staff within a two month period (ten of which came from another unit) had the effect of producing a split between old and new staff within the nursing team. The split was also reflected in the uniforms worn by staff because the staff that had been redeployed from another unit wore different uniforms to the staff who were already working at Aspen Centre. Staff from all disciplines noted difficulties the new staffing arrangements had presented to the service. Whilst staff were relieved that the serious shortage of staff within the nursing team had been

Detailed findings from this inspection

addressed, many were concerned at the impact the introduction of so many new staff, within a short period of time, had had on the running of the unit. They also expressed concern that half of the nursing team did not have any prior experience of working in the field of eating disorders and noted the importance for the whole team to understand the philosophy and rationale that supports effective treatment outcomes in an eating disorder service. There was a belief by some staff that the experience of those who had been at the unit for some time was no longer valued. However, staff appeared to be enthusiastic and engaged with their roles. They demonstrated a commitment to providing quality care and treatment for their patients. The multidisciplinary team all showed a commitment to developing the new nurse team by supporting them to increase their skills and knowledge in the field of eating disorders.

- Staff were kept up to date about developments in the trust with newsletters and email bulletins.
- There were learning and development opportunities for staff. Nurses could study toward nurse prescribing, leadership and therapy qualifications. Healthcare support workers could train in venepuncture so they could take blood samples for patients. The trust supported staff with these development opportunities.
- Staff were open and transparent with patients when things went wrong. We saw examples of staff discussing incidents with patients.

Commitment to quality improvement and innovation

- Aspen Centre had applied to become accredited with the Royal College of Psychiatrists' Quality Network for Eating Disorders. Staff had been trying to apply for a number of years but had difficulty getting approval from senior managers to fund the application and staff shortages had affected their ability to complete the self-assessment process. Staff told us that several organisational leadership changes had also affected their ability to progress their application.
- The service had taken part in a recent research programme to evaluate the use of guided self-help in anorexia nervosa. They were scheduled to take part in a local study into the experiences of compassion focused therapy in people with low weight. The service had been successful in securing a significant research bid from a medical research charity to develop a clinical screening tool for eating disorders in type 1 diabetes. Unfortunately, they did not have enough staff to manage the data collection and had to return the research funding.
- Staff had recently produced an information guide to eating disorders for clinicians. The guide provided information about the different types of eating disorder, assessment and treatment. It provided references to further reading and useful contacts for patients.
- The service had developed a complex bulimia programme for patients who also had a history of substance misuse and / or self-harm. They wanted to evaluate the service, which they believed to be the first of its kind in the country. However, staff did not have capacity to collect and analyse the data and there were no posts for psychology assistants in the team to support with the task.

Outstanding practice

- The service had developed a complex bulimia programme for patients who also had a history of substance misuse and/or self-harm.
- The service had recently produced an information guide to eating disorders for clinicians. The guide provided useful information about the different types of eating disorder, assessment and treatment. It provided references to further reading and useful contacts for patients.

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- The ward consultant had worked with the local area prescribing committee to develop a protocol for the treatment of vitamin D deficiency in anorexia nervosa. The ward consultant had also worked with the local hepatology and pharmacy departments to develop guidance for the prescribing of paracetamol. These supported on call doctors, who may not be familiar with the patient group at Aspen Centre.

Areas for improvement

The trust must ensure that effective governance is in place to monitor the quality and safety of the service and to drive improvements.

- The trust should ensure all staff are up-to-date with training in the Mental Health Act and Mental Health Act Code of Practice.
- The trust should ensure that staff are supported to learn from incidents and receive feedback about incidents they have reported.
- The trust should ensure that newly recruited staff are given the relevant learning and development opportunities to effectively work in an eating disorders service.
- The trust should ensure that patient records are easy for staff to navigate, so they can find the information they need in a timely manner.
- The trust should ensure the service resumes regular team meetings and governance meetings to keep staff appraised of developments and risks.
- The trust should routinely gather and analyse feedback from patients about their experience of the service, so they can identify themes to address.
- The trust should ensure that all staff receive a thorough induction when they are recruited to the service, which considers the specific needs and risks of patients with eating disorders.
- The trust should ensure that routine maintenance issues are dealt with in a timely manner
- The trust should consider ways to integrate the old and new nursing team.
- The trust should ensure patients and families know how to make a complaint about the service.
- The trust should ensure that all staff knock patient bedroom doors before entering.
- The trust should ensure that patients have access to meaningful activities seven days a week.

Our inspection team

Team leader: Claire Harper, Inspector, CQC

The team that inspected Aspen Centre comprised two CQC inspectors, a CQC inspection manager, a specialist eating disorders nurse and an expert by experience. An expert by experience is a person with experience of using services or caring for someone using services.

We inspected this service because, as part of our intelligence monitoring, we had received concerns about staffing levels at the Aspen Centre inpatient unit. This was an unannounced comprehensive inspection.

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

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

Before the inspection visit, we reviewed information we held about Aspen Centre.

During the inspection visit, the inspection team:

- visited Aspen Centre to look at the quality of the environment and observed how staff were caring for patients
- spoke with seven patients
- spoke with four relatives of patients
- looked at six patient care and treatment records
- looked in detail at the treatment journey of two patients
- spoke with the ward manager and their line manager
- spoke with 16 other staff members; including administrators, doctors, healthcare support workers, nurses, therapists, the dietician, an occupational therapist, a cleaner, a facilities technician and kitchen staff
- received feedback about the service from an external professional and the advocacy service
- attended and observed a ward round for two patients
- carried out a specific check of the medication management on the unit and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Aspen Centre provides specialist eating disorders treatment for adults and young people over the age of 16. It is part of Coventry and Warwickshire Partnership NHS Trust eating disorders service. The trust has been commissioned to provide an eating disorder inpatient service since 1995. Following a change in contractual arrangements, the current configuration began in April 2010, when it was then known as Woodleigh Beeches. The service became known as Aspen Centre in January 2012.

The service is commissioned by NHS England and admits patients from the local area and elsewhere.

Aspen Centre is located in Warwick, on the Warwick Hospital site. The building is single storey with a small garden at the rear. The unit is accessible by public transport with pay and display car-parking facilities.

Our inspection team

Aspen Centre is registered for the following activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury

The unit has 15 beds but, due to staff shortages in the nursing team, the service had restricted admissions to 12 patients in March 2016. There were 12 patients admitted to the unit when we carried out our inspection. None of the patients were detained under the Mental Health Act or under a Mental Capacity Act Deprivation of Liberty Safeguards authorisation.

This inspection looked at the Aspen Centre inpatient service.

CQC last inspected Aspen Centre in January 2014. The service was not rated at that inspection. The Care Quality Commission carried out a scheduled Mental Health Act monitoring visit in July 2016 and issued the trust with the report in August 2016. The trust supplied the Care Quality Commission with their provider action statement by the due date of 20 September 2016. A provider action statement details what actions a provider will take as a result of the monitoring visit.

Feedback was mostly positive about the care and treatment provided by Aspen Centre. Patients and relatives felt supported by staff. They told us that staff were polite and respectful, that they treated them with care and with dignity.

Patients said they felt safe at Aspen Centre and were confident to raise issues with staff if they needed to.

Families said they had not been told how to make a complaint about the service. However, they were sure staff would listen if they did complain.

Patients understood their care and treatment plans. They enjoyed the activities and therapy sessions available to them and since more nurses had been recruited, activities were rarely cancelled.

Patients and relatives told us that the nursing team had been really understaffed until recently, which meant there had been a high number of agency and bank staff working on the ward. Patients told us they found this frustrating because these staff were unfamiliar with the ward and not experienced with eating disorders. Relatives told us it made patients anxious when they had to explain their treatment plans to staff or when staff told them they did not understand how to set up nasogastric feeding. Patients and relatives told us that staffing had been improving since December 2016.

Patients said that resolving repairs and maintenance was a very slow process.

Patients and relatives told us that they were not routinely asked to provide feedback about the service.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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.