Barnet, Enfield and Haringey Mental Health NHS Trust

Specialist eating disorders services

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRP46	St Ann's Hospital	Phoenix Wing	N15 3TH

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust.

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have not rated this service because this was a focussed inspection.

We found the following areas where the service needs to improve:

The layout of the ward did not meet the needs of the patients. Rooms on the ward were used for outpatient appointments which did not protect the privacy of patients that were staying on the ward. Four bedrooms were located away from the main ward area which made it hard for staff to observe and support patients when they were in these rooms. During the inspection the safety and security of the ward for the patients was reduced as the front door had been left unlocked and rooms which we were told have been locked to maintain patient safety such as the laundry room had been left unlocked.

The ward had two blanket restrictions in place. The first was that patients were prevented from leaving their bedrooms for up to seven days after admission. This was not appropriate clinical practice and the blanket approach did not reflect the individual needs of the patients. Staff told us that patients could be physically unwell and would require close supervision and monitoring on admission. Patients told us that staff had shouted at them when they had attempted to leave their bedroom and that they did not understand the reason for the rule. The second blanket restriction was that the ward was only allowing patients an hour in the morning and in the evening to use the bath and shower facilities. The rule applied to all patients and was not based on individual need.

Patient records did not demonstrate that staff updated risk assessments regularly. Risk assessments were completed on admission and then reviewed at 6 month intervals, but not in relation to the changing needs of the patients.

Staff had attended specialist workshops and seminars. However, staff attendance rates were not available for the sessions provided. The trust provided specialist training to all qualified staff on the ward in nasogastric (NG) feeding.

The ward staff were not receiving regular supervision to support them to carry out their roles. When supervision did take place this was not always completed thoroughly to consider staff development needs.

As required medicines was not reviewed regularly and some medicines were prescribed above British National Formulary (BNF) recommended limits.

Incident records demonstrated that physical intervention had not been required for NG feeding.

The food available did not always meet some patients' individual meal plans. Some food choices that were included in individual meal plans were either unavailable or stock was limited. This meant that some patients would not have a snack, and therefore not eat.

Patients were not happy on the ward and felt that some staff were approachable but others were not. Complaints reflected that patients were not happy with how staff had treated them. Patients did not feel listened to and were not fully informed of ward decisions.

Overall, there were areas of practice on the ward which required considerable improvement.

However, we also found the following areas of good practice:

The ward environment was clean and free from clutter. The ward provided good access to advocacy services and supported patients to make contact with advocates when required.

The ward had good links with the local general hospital and was able to gain support and advice if concerned about a patient's physical health.

A multidisciplinary meeting took place on the ward on a daily basis where staff discussed patients that may require an admission to the inpatient unit. The meeting was well attended by various professionals who provided specialist input.

Summary of findings

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

Are services safe?

- The layout of the ward did not meet the needs of the patients. Rooms on the ward were used for outpatient appointments which did not protect the privacy of patients that were staying on the ward. Four bedrooms were located away from the main ward area which made it hard for staff to observe and support patients when they were in these rooms. During the inspection the safety and security of the ward for the patients was reduced as the front door had been left unlocked and rooms which we were told have been locked to maintain patient safety such as the laundry room had been left unlocked.
- The ward had two blanket restrictions in place. The first was that patients were prevented from leaving their bedrooms for up to seven days after admission. This is not appropriate clinical practice and the blanket approach did not reflect the individual needs of the patients. Staff told us that patients could be physically unwell and would require close supervision and monitoring on admission. Patients told us staff had shouted at them when they had attempted to leave their bedroom and that they did not understand the reason for the rule. The second blanket restriction was that the ward was only allowing patients an hour in the morning and in the evening to use the bath and shower facilities.The rule applied to all patients and was not based on individual need.
- Patient records did not demonstrate that staff updated risk assessments regularly. Risk assessments were completed on admission and then reviewed at 6 month intervals, but not in relation to the changing needs of the patients.
- Staff were not given opportunities to learn from the outcomes of incidents and complaints. After a recent investigation on the ward, senior management had not fed back information to the team in relation to the findings and areas for improvement. Team meeting minutes did not demonstrate that staff discussed complaints and investigations.
- The provider told us that catering staff had been trained in food hygiene and were the only members of staff to handle food. However, training compliance rates were not available to demonstrate this.

Summary of findings

- Incident records showed that the ward staff were not appropriately reporting all medicine administration errors. This was poor practice and presented a risk that incidents were not being investigated properly and patients could have been at risk of harm.

However, the ward environment was clean and free from clutter.

Are services effective?

- Adequate specialist training was not provided to all staff on the ward in order to equip them to care for patients who had an eating disorder.
- Care records did not demonstrate that patients were involved in decision making and the records lacked the 'patient voice'. The records did not clearly demonstrate how patients were progressing in their recovery.

However, the ward had links with the local general hospital and was able to gain support and advice if required. A multidisciplinary meeting took place on a daily basis which discussed patients that may require an admission to the inpatient unit. The meeting was well attended by various professionals in order to provide specialist input.

Are services caring?

- Patients did not feel that the staff were engaging and felt that the attitude of some staff on the ward was poor. Patients felt that they were not informed of decisions made on the ward and the reasons for ward restrictions.
- The provision of food for snacks did not always meet patients' individual meal plans. Food choices that were included in individual meal plans were either unavailable or stock was limited. This meant that some patients would not have snacks and therefore not eat.

However, the patients on the ward had good access to advocacy services and advocates visited the ward regularly to speak with patients. The ward had a daily planning meeting which provided an opportunity for staff and patients to discuss the day and raise any concerns or questions.

Summary of findings

Information about the service

Phoenix Wing is located at St. Ann's Hospital and provides specialist inpatient treatment to male and female patients aged over 18 who have an eating disorder. The ward is a 15 bedded unit and at the time of inspection the ward had 13 patients in treatment.

The ward had not been inspected by the CQC before. The service was registered to carry out the following regulated activities, treatment of disease disorder or injury, assessment or medical treatment for persons detained under the Mental Health Act 1983 and diagnostic and screening procedures.

Our inspection team

The team consisted of three CQC inspectors and a specialist advisor who was a psychiatrist with experience of working with adults who have an eating disorder.

Why we carried out this inspection

We carried out an unannounced inspection to Phoenix Wing due to concerns and complaints that were raised with us in relation to how patients were being treated on the ward.

This was a responsive inspection and specifically focused on three domains which were safe care and treatment, how effectively the service was operating and whether the culture on the ward was caring.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service and reviewed the complaints and concerns that had been raised with us.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- interviewed the ward manager
- spoke with nine other staff members including doctors, nurses and healthcare assistants and interviewed the service manager with responsibility for the service
- attended and observed one hand-over meeting and one multidisciplinary meeting
- looked at eight treatment records of patients
- carried out a specific check of the medication management on the ward and reviewed 13 medicine administration charts
- looked at training records, a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

The feedback we received from patients was mostly negative. Patients told us there was a clear difference between some staff and their approach. Some staff were friendly and approachable, and other staff did not engage

Summary of findings

with patients and did not show they cared. Key issues raised with us included lack of staff knowledge in working with patients who have an eating disorder, medication administration errors and not feeling listened to by the ward staff.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that blanket restrictions are reviewed and only used in response to a current individual patient risk. This includes set bath and shower times and patients having to remain in their rooms after admission.
- The trust must ensure patient risk assessments are completed with sufficient detail and updated following incidents and risk events.
- The trust must ensure that there is adequate food provision in order to meet patients' individual meal plans and requests. This includes the meals prepared on the ward corresponding to the food menu.
- The trust must ensure that medicine administrations charts and dosages are reviewed regularly and are in accordance with British National Formulary (BNF) recommended limits.
- The trust must ensure that all staff receive regular supervision and this is recorded and monitored. Staff must also have access to training to prepare them for caring for patients with an eating disorder.
- The trust must ensure that all staff understand incidents that require formal reporting. This includes incidents which relate to medicine administration errors.

Action the provider SHOULD take to improve

- The trust should ensure that all doors which the ward has deemed should be locked to maintain patient safety are kept locked at all times.
- The trust should address the layout of the ward so that outpatients are not visiting the inpatient unit for appointments.
- The trust should ensure all clinical equipment is regularly checked and calibrated. Also the expiry date for emergency medication should be clearly recorded so staff know when it needs to be replaced.
- The trust should ensure that the 'patient at a glance' board is regularly updated to ensure that the most current information is available to staff.
- The trust should ensure that staff are updated and made aware of outcomes from complaints and investigations as soon as reasonably possible. This includes team discussions being appropriately documented.
- The trust should ensure that physical health checks are documented correctly using the MEWS charts and any abnormal results are escalated appropriately. This includes the ward having access to MEWS charts that are printed in colour.
- The trust should ensure that patient care records are recovery focused, include patient involvement and document patients' 1:1 time with their named nurse.

Barnet, Enfield and Haringey Mental Health NHS Trust

Specialist eating disorders services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Phoenix Wing	St Ann's Hospital

Mental Health Act responsibilities

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

The trust did not provide mandatory training for the MHA although ongoing training was provided. There was no record on the ward of who had completed this training. Overall detention paperwork was completed and filled in appropriately. However, leave forms for detained patients were not stored on the ward, therefore staff and patients were unable to review the form when required.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust did not provide mandatory MCA training although ongoing training was provided. There was no record on the ward of who had completed this training. Staff had a varied understanding of the MCA. Some staff had knowledge of the guiding principles and other staff had no knowledge at all. The medical staff completed capacity assessments.

Are services safe?

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

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

Our findings

This inspection was a focused inspection to follow up identified concerns.

Safe and clean environment

- The service was located on the first floor of Phoenix Wing. The ward was a locked ward; however, at the beginning of the inspection, the inspection team found the main front door unlocked and open. This was a security issue and ward staff were made aware of this. The door was immediately locked afterwards. Staff told us that the main front door was always locked and mostly used for visitors and outpatients. The rear door to the ward was used for patients who were staying on the ward.
- The ward layout meant that meetings rooms on the ward were also shared with the outpatient unit. Outpatients would attend the ward for appointments as there was not a separate department for this. The ward manager told us that there was a business case put forward to the trust in order to make the ward inpatient only but this had not yet been approved. The ward manager recognised that the layout of the ward was not appropriate.
- The ward layout did not provide a clear line of sight in order for staff to see patients in all areas of the ward. The ward manager had recognised there was an issue with the layout of the ward as four bedrooms were located in a separate corridor which was separated by a fire door.
- The environment was clean, free from clutter and well maintained. Regular environmental checks were undertaken daily which included checking windows, doors, food in the fridges and general maintenance. Staff told us that the ward clerk reported issues to estates and facilities electronically. However, staff told us that the response from estates and facilities was slow. A toilet was blocked on the ward and the sanitary bin had not been emptied in weeks. The issues were rectified during the inspection. The ward carried out infection control assessments and handwashing posters were visible around the ward along with appropriate handwashing facilities.
- Patients told us that members of staff that served food on the ward did not always wear the appropriate clothing and hair nets when serving. Training records did not show that staff were trained in food preparation or handling food.
- The ward laundry room and one of the shower rooms was found unlocked. This was escalated to the ward staff. The staff told us that toilets and shower rooms were always locked due to nature of the patient group on the ward. Staff were not closely monitoring this as the shower room near the reception was unlocked again during the inspection.
- The ward had many ligature anchor points and none of the rooms on the ward were ligature free. The ward ligature audits completed in March 2015 stated that risks were mitigated by staff observation and supervised use of rooms. The trust had a comprehensive ligature reduction plan which had already started. The audits did not state the timescales for this work to be completed. The wards had windows which had metal window restrictors. The sanitary wares in bathrooms were not ligature free and were a part of the programme to be changed. Bedrooms had ligature points which included television cables, cupboard handles and fans. Staff told us that it was rare to have patients who were a ligature risk. The ward managed the risk by completing daily environmental checks and patient observations as well as completing individual risk assessments.
- The ward provided care and treatment to male and female patients. The ward complied with Department of Health's guidance on mixed-gender accommodation. Male and female patients had separate bathrooms and did not need to pass through the same corridor to access bathroom facilities.
- The ward had a fully equipped clinic room which included access to resuscitation equipment and emergency medication. Staff checked these on a weekly basis in accordance with the trust resuscitation policy.

Are services safe?

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

However, the emergency equipment bag had been opened due to an incident that had occurred the night before our inspection. The ward staff had not replaced the bag after the incident but this was addressed during the inspection.

- The emergency drug and equipment checklist was available. However, the checklist sheet was missing the overall expiry date for the emergency drug box. The checklist for the emergency equipment bag stated that the expiry date was a 'long expiry'. No specific date was documented. This meant that staff were not formally checking the date as required. This was escalated to the ward manager to rectify.
- Staff regularly checked and recorded fridge temperatures. Documentation for the previous three months was available. The clinical room fridge was found to be unlocked although this was addressed during the inspection. A pharmacy audit which was carried out over the past six months recognised that the clinical room temperature was not routinely below 25 degrees. The audit provided a plan of how to escalate this issue when temperatures were out of range. However, this instruction was not clearly displayed for all staff and was not routinely raised to staff in team meetings.
- The weighing scales and electrocardiogram (ECG) machine had been appropriately checked and maintained. However, the diabetes blood monitoring machine had not been checked and maintained since December 2015. This was raised with staff on the ward.
- There were panic alarms placed around the ward in order to raise an alert in an emergency. The staff told us this was to alert members of the emergency response team to an incident.

Safe staffing

- Safer staffing levels were audited by the trust and records showed that these had largely been achieved on the ward. Records showed that the ward had been above 95% of the agreed staffing levels over the past 12 months. The ward employed bank and agency staff in order to cover staff vacancies and sickness. The ward manager told us that when required the staffing numbers could be increased.
- All staff we spoke with felt that the staffing numbers on the ward were not enough as they were not able to spend time engaging with patients. Staff told us that the staffing ratio was two qualified nursing staff and two support workers on the ward at all times. Staff told us it was difficult to employ people with specialist skills in eating disorders and most agency staff did not have experience of the patient group. Members of staff we spoke with on the day had not had a break.
- Patients were allocated a primary nurse who was expected to meet with patients regularly and provide support throughout admission. Staff told us that they try to have individual 1 to 1 meetings with patients but at times it was difficult due to workload.
- The average sickness rate for the past 12 months had been low at 2%. Staff sickness was highest in May 2015 where sickness was 4.1% and this was due to short periods of sickness.
- The average turnover rate in the past 12 months had been 19%. The ward needed more qualified nursing staff and was actively recruiting for the vacant posts. The ward had employed a member of staff who was dual qualified in social work and mental health nursing. The ward had identified that many patients had social care needs that required specialist support and knowledge.
- The ward had medical cover out of hours and at the weekends. There was one doctor that covered the hospital site that staff could contact when required. However, staff told us that the doctor covered many wards and at times another hospital site; therefore it was difficult for a doctor to attend the ward. Staff told us that the 136 suite took priority.
- The trust provided regular mandatory training and the ward staff attended regular training updates. The average mandatory training rate for staff was 92% and the trust target was 85%. The ward manager told us they reviewed and monitored mandatory training progress and poor completion was raised within supervision.

Assessing and managing risk to patients and staff

- The ward manager told us that the ward did not use the hospital seclusion facilities as this was not required for the patient group. Staff told us that they were able to de-escalate incidents where patients were distressed on

the ward and restraint was used as a last resort. Staff told us that restraint may be required for patients that needed nasogastric (NG) feeding. However, there had been no incidents of restraint formally reported for NG feeding. Records showed that only one episode of restraint had taken place on the ward in the past 12 months.

- Six of eight care records reviewed did not include up-to-date risk assessments. Risk assessments were not always very thorough. For example, a patient had absconded but the risk assessment did not clearly explain how that risk would be managed in the future. Overall the risk assessments were completed on admission and reviewed six monthly. Records showed that medical staff mostly completed risk assessments and updated them. Other members of the team are not updating the risk assessments as needed.
- The 'patient at a glance' board within the nursing office did not accurately reflect the information in the patient record system. For example, patient risk assessment dates were shown to be outdated on the board, but the electronic notes showed that assessments had been updated. This could pose a risk of incorrect information being communicated across the team.
- The ward operated blanket restrictions. We heard from staff and recently admitted patients that on admission patients were required to stay in their bedrooms for the first seven days. The ward staff and patients did not understand the reason for the admission rule. Staff told us that they believed it was so that patients could be observed closely for any physical concerns. Senior staff told us that that the rule had always been in place and had not been reviewed. Patients were not fully aware of the reasons behind the rule and told us that staff said it was due to needing time to reflect. A recently admitted patient told us that on one occasion a member of staff had shouted at them as they wanted to leave their bedroom. This was raised immediately with the service manager and the ward manager. The service manager had believed this restrictive practice had stopped. Our concerns were escalated to senior managers in order for the restriction to be reviewed immediately.
- The ward had set times for laundry, medication and using bathroom facilities to bath or shower. Patients that wanted to use washing facilities in the morning would only be able to use the facilities between 6am and 7am and again for an hour in the evening. This was a blanket rule as the times identified were not flexible or based on individual need.
- Staff told us that they felt at times the senior managers and medical staff did not take on board the opinions of the qualified nurses and health care assistants when considering risk. For example, they talked about decisions relating to patients taking leave.
- Informal patient care records included up-to-date information on informal patients' rights. The ward staff told us that informal patients would require a risk assessment prior to leaving the ward and this would be carried out by medical staff. If a doctor was unavailable the ward staff would attempt to delay the patient wanting to leave the ward. However, staff were clear that they would not tell patients they were unable to leave the ward.
- The trust had policies and procedures in place for the use of observation and searching patients. Staff told us that there had been problems with informal patients bringing banned items onto the ward for other patients, for example laxatives. Staff searched visitor and patient bags and at times carried out a 'pat down' search when required on patients. Staff did not carry out full body searches. Staff were aware of having to ask for consent and use staff of the same gender when searching patients. Staff told us they spoke with patients who brought banned items onto the ward in relation to the risks involved. Staff told us that they documented when a search took place and items removed were noted.
- The ward used appropriate and clearly documented medicines administration charts. There was a trust pharmacy on site that provided support to the ward. Pharmacists visited regularly and replenished stock.
- The medicine administration charts did not show that there were any unsigned for medicines. However, a pharmacy audit that was carried out in the past two months demonstrated that overall the ward scored 80% in January 2016, as there had been two medicine charts which showed blank gaps in administration.Patients told us that there were occasions where they had returned medication to the member of staff who was dispensing it due to the incorrect medicine or dosage given. One patient told us they were given medication at

the wrong time of day. Incident records showed that in February 2016 only one medication incident was reported which involved medication that was dispensed incorrectly. This meant that staff were not formally reporting administration errors or incidents where patients have returned incorrect medication.

- Meeting minutes from October 2015 raised an issue around medication administration charts not being completed appropriately. The charts had frequent blank boxes which meant staff were not appropriately signing for medication once administered. There was no action or update to staff about this.
- Restraint and the use of rapid tranquilisation (RT) was rarely used on the ward. Patients echoed this and told us that restraints rarely happened on the ward.
- Staff were trained in safeguarding vulnerable adults and children. Some staff were confident of how to raise concerns, others were less sure. In the past 12 months no safeguarding concerns had been raised by the ward.
- Children and young people could visit the ward. However, children over 12 years of age could visit the ward but would stay in the group room. At times young people would be chaperoned by another adult. Children under the age of 12 would be risk assessed as to whether it was appropriate to visit the ward.

Track record on safety

- The ward had two serious incidents reported within the past 12 months involving an attempted suicide and one community death.

Reporting incidents and learning from when things go wrong

- Staff were not always made aware of investigations that had taken place on the ward and across the trust. Outcomes of incidents had not been communicated with the team. Staff recognised that the dissemination of information required improvement. A recent complaint had triggered an investigation into how the ward was managed. Staff we spoke with were not fully aware of the investigation and were told by senior management that the final report needed to be edited prior to the ward staff being able to read it. Staff told us that they were interviewed by trust senior managers but they were not told any further information. This was raised with the ward manager and service manager for Phoenix Wing. The service manager was unaware that the ward staff had not been updated about the investigation.
- Staff knew what kind of incidents needed to be reported and knew the process for completing electronic incident forms and alerting relevant parties.
- Staff told us that concerns and incidents would be discussed in monthly clinical governance meetings. However, meeting minutes for the past six months did not demonstrate that incidents were regularly discussed and incidents were not an item on the agenda.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- In all eight patient records reviewed, staff had assessed each patient upon admission and completed a comprehensive physical health examination which was appropriately documented. Patient records all demonstrated that ongoing monitoring of physical health checks and blood investigations took place. However, routine physical health monitoring and actions were not always documented appropriately. For example, one patient had a raised pulse and blood pressure. The electronic record did not mention the action taken by the member of staff and the clinical note stated 'within normal range'.
- Staff used a tool to monitor patients' physical health. This was the modified early warning scores (MEWS) tool. Staff examined patients' vital physical health signs, including blood pressure and then converted the results of the examination into a score. The higher the score the more abnormal the results. However, staff were not using MEWS charts in colour which made it difficult to see the results clearly. The ward manager told us that this was due to the ward not having a colour printer as there had been funding issues. The MEWS charts not printed in colour creates a risk that the sheets do not clearly show an abnormal range. For example, the red colour demonstrates that the score is out of range and would require escalation. The charts did not specify the escalation process if a result was abnormal.
- Staff completed care records of patients upon admission. Some of the records we looked at were detailed, stating how the staff would meet patients' needs. However, seven out of eight of the records we looked at showed minimal or no involvement of the patient and were not personalised. Three of the records demonstrated a lack of focus on goals for patients to work towards during their admission. Two separate care records were not up to date. This was reflected within the patient and carer survey which collects information in relation to patient involvement, dignity and respect and information provided. The survey in October 2015 demonstrated that overall the ward scored 37% and the trust target was 80%.
- Staff on the wards securely stored all information concerning patients and this was accessible to most of the staff on the wards. However, agency staff were not able to access patients' electronic records. This created a risk that agency staff were not able to access important information concerning patients' care and treatment.

Best practice in treatment and care

- The national institute for health and care excellence (NICE) guidelines were mostly being met in relation to the management and prescribing of medication. Out of the 13 medicine administration charts reviewed, two separate charts showed that medication was prescribed above British National Formulary (BNF) recommended limits. One chart did not demonstrate that a medication which was prescribed 'when required' had been reviewed after 14 days.
- The ward had a part-time clinical psychologist who provided cognitive behavioural therapy (CBT), psychotherapy and art therapy to patients. Staff told us that a psychologist from the outpatient department had been allocated to Phoenix wing for two days a week since December 2015. Prior to this, the ward was providing psychology groups only and specialist psychology input was minimal. The ward psychologist was involved in assessing patients on admission, providing brief individual therapy if required and involved in discharge planning.
- The ward had links with North Middlesex Hospital and was able to refer if there were concerns about a patient's physical health.
- Senior nurses carried out clinical audits including infection control audits and care plan audits. Ward staff did not generally complete audits unless staff specified an interest.

Skilled staff to deliver care

- The staff working on the ward were from medical, nursing, psychology and occupational therapy backgrounds. The ward had an identified pharmacist who visited the ward regularly.
- Newly qualified staff told us that they had completed mentorship training and felt that they had good learning opportunities.

Are services effective?

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

- The ward manager told us that staff were trained in phlebotomy and that all qualified staff were trained in nasogastric feeding. Staff had opportunities to attend seminars which included discussions around personality disorder and workshops that included working with carers. Records demonstrated qualified staff had attended training on NG feeding.However, staff attendance and compliance rates were not available on the ward for specialist workshops, seminars and other training. Staff had not received specific training on caring for people with an eating disorder in order to equip them to work with this specialist patient group. New staff received an induction to the ward and also a two-day formal trust induction.
- Staff did not receive regular individual supervision. In total, three supervision records were reviewed which showed that supervision was not taking place on a monthly basis. None of the records covered areas such as the staff members well-being, work performance and training needs. The ward manager told us that poor performance and sickness was raised within individual supervision.

Multi-disciplinary and inter-agency team work

- We observed two multidisciplinary (MDT) meetings on the ward. One of the meetings was called the clinical forum meeting which included the inpatient ward manager, outpatient staff, eating disorder liaison worker, dietician, psychology and medical staff. The meeting provided an opportunity to discuss patients on their caseloads and patients they were concerned about in the community. Staff reviewed patient risk and identified patients that may require admission. The meeting demonstrated good practice in joint working with other hospitals. We observed a separate handover style meeting where individual patients were discussed and staff highlighted patients medication, mood and meal plan.
- Staff we spoke with told us that they felt that team work needed to improve as communication between medical staff and nurses was not always effective. Staff told us that they do not always feel listened to and the ward did not do well in pre-planning and was reactive to situations when they occurred. Nursing staff told us that they emailed the ward manager, senior medical staff and managers in order to be heard. Team meeting minutes demonstrated that staff attitude and team work was an ongoing issue.

Adherence to the MHA and the MHA Code of Practice

- Overall, in three patient records we reviewed, the MHA detention paperwork was filled in correctly, was up to date and was stored correctly. However, leave forms for detained patients could not be found electronically. Staff told us that patients were verbally told and did not receive a copy of their leave form. A copy of the forms were not kept on the ward as they were sent to the Mental Health Act office to be stored.
- For patients that were detained under the MHA, their rights were being explained and this was recorded.
- Out of the 13 medication administration chart reviewed, one consent to treatment form was appropriately completed and attached. The other 12 charts were either for informal patients or patients that had recently been placed under the MHA, therefore would not require a consent to treatment form at the time of our inspection.
- The ward was supported by the on-site Mental Health Act office. MHA records were held centrally and the ward staff could contact the team for advice and support.

Good practice in applying the MCA

- In the past six months, no Deprivation of Liberty (DoLS) applications had been made.

  Overall, staff understanding of the use of the MCA and their responsibility for assessing capacity varied on the ward. Staff told us that assessing capacity was the responsibility of the doctor and that they did not get involved in capacity assessments.
- The trust had a policy on the MCA available on the intranet. An audit which included aspects of the MCA showed that records for informal patients on the ward in October 2015 did not include a completed record of the patients' mental capacity being assessed to ensure they consented to their treatment.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed mixed interactions between staff and patients. Some staff engaged more with patients than others and showed a caring attitude. Patients told us that some staff were dismissive and they wanted a higher level of engagement.
- The ward provided a 'do's and don'ts' list to bank and agency staff. This included subjects that the staff should not discuss with the patients and things which they should and shouldn't say. For example, 'do not shout private questions out across rooms, ask privately', 'do show enthusiasm'. The ward manager told us that this was created after a recent complaint as the ward acknowledged that some bank and agency staff were not always trained with working with patients who have an eating disorder.
- Patients told us that staff were not always understanding of patient needs and did not always react to situations as required. Patients felt that not all staff understood patients with an eating disorder. Patients told us that they did not complain anymore as nothing changes and told us that the only change within the ward was the regular change of staff.
- Patients told us that staff needed to engage with patients more often. Patients told us that they felt they could only approach specific members of staff. The ward manager was aware of patients not feeling able to approach certain members of staff. However, there were no plans in place in order to address the relationship between staff and patients.
- Patients did not always receive the snack or meal that was documented within their meal plan and no other alternative option was provided. Patients told us that there was not always enough food to accommodate all meal plan options and are told by some staff that they would be required to choose something else or they will document it is a refusal. Patients told us that meals that were served did not always correspond to the menu. We observed patients discussing the options for food from the smell of the food cooking. Patients told us that at times this was the only way of knowing. The ward had a folder which kept a record of meal plans for each patient per week and at times recorded when patients refused their meal. However, the records did not include that the supply of some food options was limited.

The involvement of people in the care they receive

- Patients told us that they were not actively involved within the planning of their care. Patients that were detained did not fully understand why they were detained under the MHA. Some patients told us they were given paperwork which included a care plan and others told us that they did not receive a copy of their care plan. One patient told us that they did not understand why their vital signs were being checked so frequently as staff had not explained the reasons.
- Patients told us that that issues on the ward were rarely addressed. The service director had told patients to email the senior management team if they were unable to resolve the issue on the ward within three weeks.
- Patients told us that they were not always allowed visitors and this was limited during the first seven days of admission. The ward manager told us that this was on an individual basis and was usually because of complicated family dynamics.
- The ward provided good access for patients to contact and meet with advocacy services. Advocates regularly attended the ward community meetings and patients could also contact them independently when required.
- The ward had daily planning meetings which involved staff and patients on the ward. The meeting provided an opportunity to discuss the activities on the ward and for questions and concerns to be raised.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. Blanket restrictions were in place as patients were to stay in their bedroom for seven days after admission. Patients also had set times to use the bath and shower facilities. The food provision on the ward did not meet the needs of the patients' individual meal plans. This included the food menu not corresponding to the food that was available to patients at mealtimes. This was a breach of regulation 9(1)(2)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that care and treatment was provided in a safe way for patients. Patient risk assessments were not always completed with sufficient detail and were not regularly updated. Staff were not appropriately reporting incidents formally which related to medicine administration errors. Medicine administrations charts and dosages were not regularly reviewed and medicines had been prescribed above BNF recommended limits. This was a breach of Regulation 12 (1)(2)(a)(b)(e)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had not ensured that staff had access to regular supervision and that a record of this was maintained.

The trust had not ensured that staff had received training on how to care for patients with an eating disorder.

This was a breach of Regulation 18(1)(2)(a).